WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

WAYNE DAVISON, *Applicant*

vs.

STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS - CALIFORNIA INSTITUTE FOR WOMEN; legally uninsured, administered by STATE COMPENSATION INSURANCE FUND, *Defendants*

Adjudication Numbers: ADJ4162830 (MF) (MON 0330508); ADJ2411991 (MON 0360495)
Marina del Rey District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

Defendant seeks reconsideration of the Joint Findings, Award, and Order (JFA&O) issued on May 7, 2026 wherein the workers' compensation administrative law judge (WCJ) found, in relevant part, that while employed by defendant as a plant manager and associate warden, applicant sustained injury arising out of and occurring in the course of employment (AOE/COE) on August 31, 2007 (ADJ2411991) to the lumbar spine, cervical spine, left elbow, bilateral arms, and bilateral legs, and during the period from November 1, 1981 to June 27, 2005 (ADJ4162830), to the cervical spine, lumbar spine, bilateral shoulders, bilateral wrists, left hip, bilateral knees, GERD, hypertension, coronary artery disease and psyche. The WCJ assigned applicant to occupational group number 490 based upon his testimony that he worked as both a plant manager and associate warden and found that applicant sustained a one hundred percent (100%) permanent and total disability.

Defendant contends that applicant's psyche claim is not based upon substantial medical evidence; applicant's occupational group number should be 212 based upon applicant's deposition testimony and statements made by applicant to doctors regarding job duties; the *Almaraz Guzman* ratings of Richard Fedder, M.D. and Richard Hyman, M.D. are not substantial medical evidence; and reports of Laura Wilson on the issue of "non feasibility" of applicant's ability to return to work

are not substantial evidence as they do not comply with relevant case law. (Petition for Reconsideration (Petition), p. 2.)

We have received an Answer from applicant. The WCJ prepared a Report and Recommendation on Petition for Reconsideration (Report), recommending that the Petition be denied.

We have considered the contents of the Petition, Answer, and Report, and we have reviewed the record in this matter. For the reasons discussed below, we will deny the Petition.

FACTS

Applicant claimed that, while employed by defendant as plant manager and associate warden, he sustained injury AOE/COE on August 31, 2007 (ADJ2411991) to the lumbar spine, cervical spine, left elbow, bilateral arms, and bilateral legs, and during the period from November 1, 1981 to June 27, 2005 (ADJ4162830), to the cervical spine, lumbar spine, bilateral shoulders, bilateral wrists, left hip, bilateral knees, GERD, hypertension, coronary artery disease, psyche, congestive heart failure, and premature PVC.

The parties retained Richard Fedder, M.D. as the orthopedic Agreed Medical Evaluator (AME) and Richard Hyman, M.D. as the cardiology AME. Nelson Flores, Ph.D. was retained by applicant as a psyche medical-legal evaluator. Applicant and defendant also retained Laura Wilson and Rebecca Montano as their respective vocational experts.

Applicant underwent psyche testing and a medical-legal evaluation with Dr. Flores in 2007 with corresponding reports issuing thereafter. In his report dated July 23, 2007, Dr. Flores opined that applicant had a GAF score of fifty-eight (58) equating to an eighteen percent (18%) WPI for depression, anxiety, and sleep disorder of which eighty percent (80%) was "directly related to [applicant's] aforementioned depressive and anxiety disorders, which developed as a consequence of his exposure to incidents of stress and harassment at the work place while employed by the State of California Department of Corrections" and the remaining twenty percent (20%) attributable to "exacerbation of his depressive and anxiety disorders, and the development of his sleep disorder as a consequence of the persisting, and chronic pain and physical limitations related to the orthopedic injury he sustained while at work[.]" (Exhibit 12, pp. 3-4, 15.)

Orthopedic AME, Dr. Fedder, issued multiple reports spanning from 2012 through 2019 regarding the August 31, 2007 specific injury and the cumulative injury through June 27, 2005. He was deposed by the parties on November 14, 2014.

In his report dated October 30, 2013, Dr. Fedder opined that applicant sustained injury AOE/COE to the cervical spine, shoulders, wrists, lumbar spine, left hip, and knees with a resulting in five percent (5%) WPI to the cervical spine based upon DRE category II and effects upon activities of daily living, twenty-eight percent (28%) WPI to the lumbar spine based upon loss of range of motion, neuro deficits, and development of a specific spinal disorder, 7% WPI to each upper extremity (seven percent (7%) upper extremity impairment (UEI) due to loss of range of motion in the left shoulder, six percent (6%) UEI for loss of range of motion in the right shoulder, and a five percent (5%) UEI to each wrist for carpal tunnel), twenty percent (20%) WPI to the left hip due to a replacement surgery, three percent (3%) WPI to the left knee for surgery, one percent (1%) WPI to the right knee for surgery, and a 2% add-on for pain. (Exhibit EE, pp. 32-37.) Dr. Fedder indicated that all the orthopedic injuries were "inextricably intertwined and [impairment] should be apportioned 100% to the continuous trauma from November 1981 through June 27, 2005." (*Id.* at p. 33.)

One year post lumbar fusion, in an updated report dated May 30, 2014, Dr. Fedder opined that applicant sustained a thirty-four percent (34%) WPI to the lumbar spine resulting from loss of range of motion, muscle weakness, and a specific spinal disorder. (Exhibit DD, p. 11.)

In a final report dated March 8, 2019, Dr. Fedder continued to believe that the injuries were inextricably intertwined and that orthopedic disability should be apportioned 100% to the cumulative injury. (Exhibit HH, p. 87.) He further opined that "[i]n view of [applicant's] orthopedic problems, as well as his internal medical and psychiatric problems" applicant is "considered to be 100% totally disabled." (Exhibit HH, p. 88.) Dr. Fedder agreed with VE Wilson that applicant's "disability to earn income has been eliminated and his ability to find realistic jobs in the real world…nonexistent." He noted also that "[i]n view of the multilevel orthopedic involvement in the upper and lower extremities, as well as the neck and back, in view of the multiple surgical procedures [applicant] has had," "there is a synergistic effect between all the areas of orthopedic injury" such that the impairments should be "added rather than combined." (*Id*. at p. 91.) Thus, with respect to applicant's orthopedic claims, Dr. Fedder noted an overall seventy five percent (75%) WPI through addition of: 5% WPI to cervical spine under DRE

category II and limitations to activities of daily living, a thirty-one percent (31%) WPI to the lumbar spine (16% WPI from loss of range of motion, 15% WPI from the specific spine disorder resulting from a two level fusion, and a 2% pain add-on), eight percent (8%) and nine percent (9%) WPI to the left and right upper extremities, respectively, resulting from loss of range of motion and diagnostic studies documenting carpal tunnel, a 20% WPI to the left hip from surgery, 7% WPI to the left lower extremity from gait derangement, and 1% WPI to the right lower extremity from DBE. (*Id*. at pp. 89-91.)

Cardiology AME, Dr. Hyman, issued multiple reports spanning from 2011 through 2025 regarding the cumulative injury through June 27, 2005. In his report dated March 14, 2011, he found "no evidence of pathological cardiac arrhythmias that would rise to the level of ratable impairment." (Exhibit SS, p. 1.) In subsequent report dated September 25, 2018, he found that although applicant's diabetes had resolved with no ratable impairment, applicant sustained a twelve percent (12%) WPI with sixty percent (60%) apportionment to the cumulative injury from GERD. In reports dated June 24, 2019, January 22, 2020, and December 1, 2020, Dr. Hyman found it medically probable that applicant sustained a separate twenty-five percent (25%) WPI from deconditioning. (Exhibit OO, p. 4; Exhibit NN, p. 2; Exhibit MM, pp. 1-2.) In an August 31, 2021 report, Dr. Hyman noted that applicant's GERD had improved such that impairment would be reduced from 12% to eight percent (8%). (Exhibit JJ, p. 5.) Assuming that applicant's gastric bypass "was done for nonindustrial reasons," industrial apportionment was also reduced from 60% to forty percent (40%). (*Ibid*.) Dr. Hyman believed that applicant sustained "hypertensive heart disease" and "coronary disease requiring bypass graft surgery[,]" both of which were "100% industrial under the [heart] [p]resumption" with respective WPIs of thirty percent (30%) WPI based upon Table 4-2 and thirty-five percent (35%) WPI under Table 3-6A. (*Id*. at pp. 5-6.) Applicant's hypertension was also noted as resulting in a separate twenty-five percent (25%) WPI of which sixty-five percent (65%) was attributable to work. (Exhibit TT, p. 1.)

In a report dated November 12, 2025, Dr. Hyman opined as follows with respect to use of the addition versus combination (CVC) method of rating impairments:

> Relating to the issue of Vigil, his internal medicine problems should be additive rather than combined with any orthopedic or psychological issues as they impact his impairment in different ways.

> Concerning his internal medicine conditions, his gastrointestinal and heart problems would be considered additive as they impact impairment differently and are synergistic.
>
> All gastrointestinal problems should be combined affecting impairment similarly. This is true also of his deconditioning, coronary artery disease and hypertension which should be combined because they all affect functioning of the cardiovascular system.

(Exhibit YY, p. 4.)

On October 29, 2021, Dr. Hyman was deposed and made several updates to his opinions. In a final report dated January 7, 2026, he reiterated that due to "narcotic induced constipation" applicant sustained an 8% WPI for GERD with 40% apportionment to work. (Exhibit BBB, p. 1.) With respect to the deconditioning, hypertension, and coronary artery disease, he noted his updated findings of 15%, 30%, and 35% WPI with 100%, seventy percent (70%) and forty-five percent (45%) of the impairments attributable to the cumulative injury, respectively. (*Ibid*.)

Applicant's VE, Laura Wilson, issued numerous reports during the period from 2015 - 2023. In her initial report dated July 10, 2015, she noted that applicant was "unable to complete in the open labor market and as a result of his work related impairments, considering his preinjury capacity and abilities," he had "no consistent and stable earning capacity" which meant that he couldn't "work 5 days per week, 8 hours per day" as his "ability to work a full or part time job would require that he be able to set the total hours worked, the days and the hours worked such that he would be able to come and go as he pleased and work at his own pace and whenever he was able to physically and emotionally able to" which meant "'niche' employment, or a sheltered working environment…[that was] not consistent with the realities of the Open Labor Market." (Exhibit 11, p. 11.) Wilson confirmed her opinions in subsequent reports including her final report dated May 5, 2023, wherein she stated that applicant was still unamenable to vocational rehabilitation and unable to sustain gainful employment or compete in the open labor market due to "industrial-related impairments." (Exhibit 6, p. 33.) Applicant thus had "no consistent and stable future earning capacity." (*Ibid*.)

Defense VE, Rebecca Montano, completed a virtual evaluation of applicant on March 9, 2022, issued a corresponding report dated April 16, 2022, and was deposed by the parties on August 25, 2022. In her April 16, 2022 report, she indicated that applicant was "amenable to vocational rehabilitation" and had "marketable transferable skills that would allow him to return

to work in the capacity of part-time employment (including Parking Lot Attendant and Ticket Taker), but more appropriately work he could do at home with a flexible work schedule (Administrative Support), where he could use adaptive equipment, such as sit/stand desk, ergonomic chairs, headsets, voice active computer software as needed to complete the job safely and in comfort." (Exhibit F, p. 59.)

On August 28, 2023, applicant filed a Declaration of Readiness to Proceed to a Mandatory Settlement Conference. The matters proceeded to multiple hearings before being set for a trial on January 30, 2024, later continued to February 24, 2026.

At trial, the parties stipulated, in relevant part, to injury AOE/COE on August 31, 2007 (ADJ2411991) to the lumbar spine, cervical spine, and left elbow, and during the period from November 1, 1981 through June 27, 2005 (ADJ4162830) to the cervical spine, lumbar spine, bilateral shoulders, bilateral wrists, left hip, bilateral knees, GERD, hypertension, and coronary artery disease. Issues set for determination in both claims included body parts injured (bilateral arms and legs in ADJ2411991, and psyche, congestive heart failure, and premature PVC in ADJ4162830); permanent and stationary (P&S) date; permanent disability; apportionment; occupation and group number; need for further medical treatment; and attorney fees. Additional issues set for trial in ADJ4162830 include applicability of anti-merger under Labor Code[1] sections 3208.1 and 3208.2; whether the opinions of AME Dr. Fedder, AME Dr. Hyman and VE Wilson constitute substantial (medical) evidence; applicability of section 4061(i); and the section 4656 cap on temporary disability indemnity benefits.

On May 7, 2026, the WCJ issued a JFA&O wherein she found, in relevant part, that while employed by defendant as a plant manager and associate warden, applicant sustained injury AOE/COE on August 31, 2007 to the lumbar spine, cervical spine, left elbow, bilateral arms, and bilateral legs and during the period from November 1, 1981 to June 27, 2005 to the cervical spine, lumbar spine, bilateral shoulders, bilateral wrists, left hip, bilateral knees, GERD, hypertension, coronary artery disease and psyche. The WCJ assigned applicant to occupational group number 490 and found that applicant sustained 100% permanent and total disability.

It is from this JFA&O that defendant seeks reconsideration.

[1] All further statutory references will be to the Labor Code unless otherwise indicated.

DISCUSSION

I.

Preliminarily, former section 5909 provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.) Effective July 2, 2024, section 5909 was amended to state in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.
>
> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

Under section 5909(a), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected under the Events tab in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on June 17, 2026, and 60 days from the date of transmission is August 16, 2026, which is a Sunday. The next business that is 60 days from the date of transmission, is August 17, 2026. (See Cal. Code Regs., tit. 8, § 10600(b).)[2] This decision was issued by or on August 17, 2026, so that we have timely acted on the petition as required by section 5909(a).

Section 5909(b)(1) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to

[2] WCAB Rule 10600(b) (Cal. Code Regs., tit. 8, § 10600(b)) states that:

> Unless otherwise provided by law, if the last day for exercising or performing any right or duty to act or respond falls on a weekend, or on a holiday for which the offices of the Workers' Compensation Appeals Board are closed, the act or response may be performed or exercised upon the next business day.

act on a petition. Section 5909(b)(2) provides that service of the Report shall constitute notice of transmission.

Here, according to the proof of service for the Report, the Report was served on June 17, 2026, and the case was transmitted to the Appeals Board on June17, 2026. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that service of the Report provided accurate notice of transmission under section 5909(b)(2) because service of the Report provided actual notice to the parties as to the commencement of the 60-day period on June 17, 2026.

II.

Turning now to the merits of the Petition, it is well established that the burden of proof rests upon the party holding the affirmative of the issue. (Lab. Code, § 5705.) As such, when an employee claims injury AOE/COE, it is the employee, or the lien claimant who steps in the shoes of the employee, who carries the burden of proof in establishing industrial causation and they must show that the employment was a contributing cause. (*South Coast Framing v. Workers' Comp. Appeals Bd.* (*Clark*) (2015) 61 Cal.4th 291, 297- 298, 302; §§ 5705; 3600.) Pursuant to section 3202.5, the evidentiary burden of proof is to be met by a preponderance of the evidence. However, "[t]hat burden manifestly does not require the applicant to prove causation by scientific certainty." (*Rosas v. Worker's Comp. Appeals Bd.* (1993) 16 Cal.App.4th 1692, 1701 [58 Cal.Comp.Cases 313].)

Further, substantial medical evidence is used to establish industrial causation. "The term 'substantial evidence' means evidence which, if true, has probative force on the issues. It is more than a mere scintilla, and means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion…It must be reasonable in nature, credible, and of solid value." (*Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd.* (*Bolton*) (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566], emphasis removed and citations omitted.) Pursuant to *E.L. Yeager v. Workers' Comp. Appeals Bd.* (*Gatten*) (2006) 145 Cal.App.4th922, 928 [71 Cal.Comp.Cases 1687], "[a] medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess. (citations.) Further, a medical report is not substantial evidence unless it sets forth the reasoning behind the physician's opinion, not merely his or her conclusions.

(citation.)" "A medical report which lacks a relevant factual basis cannot rise to a higher level than its own inadequate premises. Such reports do not constitute substantial evidence to support a denial of benefits. (citation.)" (*Kyle v. Workers' Comp. Appeals Bd* (*City and County of San Francisco*) (1987) 195 Cal.App.3d 614, 621.)

Based upon our review of the reports of Dr. Flores, we believe he took an accurate and adequate history of the injury, thoroughly examined the applicant, and explained how and why industrial work exposure caused applicant's psyche complaints. As such, we believe that the reporting of Dr. Flores constitutes substantial medical evidence.

Defendant contends that the reports of Dr. Flores are unrelated to the cumulative injury through June 27, 2005, and do not "demonstrate by a preponderance of the evidence that actual events of employment were predominant as to all causes combined of the psychiatric injury" as outlined under section 3208.3(b)(1).

We disagree. In his report dated July 23, 2007, Dr. Flores opined that applicant had a GAF score of 58 equating to an 18% WPI for depression, anxiety, and sleep disorder of which 80% was "directly related to [applicant's] aforementioned depressive and anxiety disorders, which developed as a consequence of his exposure to incidents of stress and harassment at the work place while employed by the State of California Department of Corrections" and the remaining 20% attributable to "exacerbation of his depressive and anxiety disorders, and the development of his sleep disorder as a consequence of the persisting, and chronic pain and physical limitations related to the orthopedic injury he sustained while at work[.]" (Exhibit 12, pp. 3-4, 15.) Thus, per Dr. Flores, actual events of employment were not only predominant but wholly the cause of applicant's psychiatric impairment. Accordingly, the reports of Dr. Flores have satisfied the necessary requirements under section 3208.3(b)(1).

III.

Defendant's next argues that the opinions of applicant's vocational expert, Laura Wilson, on the issue of "non feasibility" of applicant's ability to return to work are not substantial evidence as they do not comply with relevant case law, including the case of *Nunes v. State of California, Dept. of Motor Vehicles* (*Nunes I*) (2023) 88 Cal.Comp.Cases 741, 749 (Appeals Bd. en banc). (Petition, p. 2.)

As explained in *Hamilton v. Lockheed Corporation* (*Hamilton*) (2001) 66 Cal.Comp.Cases 473, 476 (Appeals Bd. en banc), a decision "must be based on admitted evidence in the record" (*Id.* at p. 478) and must be supported by substantial evidence. (Lab. Code, §§ 5903, 5952, subd. (d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; *LeVesque v. Workers' Comp. Appeals Bd.* (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) "The term 'substantial evidence' means evidence which, if true, has probative force on the issues. It is more than a mere scintilla, and means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion…It must be reasonable in nature, credible, and of solid value." (*Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd.* (*Bolton*) (1983) 34 Cal.3d 159, 164 [48 Cal.Comp.Cases 566], emphasis removed and citations omitted.)

Further, it is well established that vocational evidence may be used to address issues relevant to the determination of permanent disability. While the Permanent Disability Rating Schedule (PDRS) is presumptively correct (see *Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd.* (2010) 187 Cal.App.4th 808, 826 [75 Cal.Comp.Cases 837]), "a rating obtained pursuant to the PDRS may be rebutted by showing an applicant's diminished future earning capacity is greater than that reflected in the PDRS." (*Nunes I*, *supra*, at p. 749.) Among the methods described for challenging a rating obtained under the PDRS is establishing that "the injury to the employee impairs his or her rehabilitation, and for that reason, the employee's diminished future earning capacity is greater than reflected in the employee's scheduled rating." (*Ogilvie v. Workers' Comp. Appeals Bd.* (2011) 197 Cal.App.4th 1262, 1274 [76 Cal.Comp.Cases 624].) Our opinion in *Nunes I* made clear that "[t]he same considerations used to evaluate whether a medical expert's opinion constitutes substantial evidence are equally applicable to vocational reporting … [i]n order to constitute substantial evidence, a vocational expert's opinion must detail the history and evidence in support of its conclusions, as well as 'how and why' any specific condition or factor is causing permanent disability." (*Nunes I*, *supra*, at p. 751.)

Based upon our review of the evidentiary record, including the vocational reports in this matter, we believe that VE Wilson's opinions are substantial evidence and that applicant has successfully rebutted the PDRS. Wilson completed a full assessment, took a detailed history, and provided evidence and reasoning in support of her conclusions.

Defendant contends that Wilson's findings are "based solely on the industrial related impairments and his industrial physical limitations that were provided in the medical reports of pain management Dr. Gurai and Dr. Tolentino." (Petition, pp. 16-17.) Defendant further contends that Wilson "impermissibly ignores valid apportionment given by AME Dr. Hyman" and "seemingly encompasses applicant's non-industrial psyche and the associated medication[.]" (*Id*. at p. 17.)

We disagree. As noted above, the reports of Dr. Flores constitute substantial medical evidence on the issue of applicant's psyche injury. Further, according to our review of the record, VE Wilson issued a total of six (6) reports wherein she completed multiple evaluations of applicant, and reviewed extensive records, including diagnostic exams and medical reports from various physicians. In preparation for the drafting of her initial report dated July 10, 2015, she reviewed medical reporting from Drs. Fedder, Hyman and Flores, Gary Baker, M.D., Paul Brody, M.D., Steven Moskowitz, M.D., Guy H. Gottschalk, M.D., Daniel Kharrazi, M.D., Kourosh Kevin Shamlou, M.D., Ernest C. Levister, M.D. Notably, she had not yet reviewed reports Ramandeep Gurai, M.D. or Ethelynda Tolentino, M.D. Notwithstanding the fact that she had not yet reviewed said reports, she nonetheless determined that applicant was "unable to compete in the open labor market and as a result of his work related impairments, [and] considering his preinjury capacity and abilities." (Exhibit 11, p. 11.) She noted that applicant had "no consistent and stable earning capacity" and couldn't "work 5 days per week, 8 hours per day" as his "ability to work a full or part time job would require that he be able to set the total hours worked, the days and the hours worked such that he would be able to come and go as he pleased and work at his own pace and whenever he was able to physically and emotionally able to" which meant "'niche' employment, or a sheltered working environment…[that was] not consistent with the realities of the Open Labor Market." (*Ibid*.) Wilson continued to find applicant unamenable to vocational rehabilitation and unable to compete in the open labor market throughout her reporting, including her last report dated May 5, 2023 wherein she provided a final update upon review of medical records from Drs. Gurai and Tolentino.

Further, on the issue of apportionment, it is well established that vocational experts must consider valid medical apportionment found by the reporting physicians. This is confirmed in *Nunes I*, wherein we held that vocational evidence must address apportionment, but such evidence "may not substitute impermissible 'vocational apportionment' in place of otherwise valid medical

apportionment." (*Nunes I*, *supra*, at p. 756.) An analysis of whether there are valid sources of apportionment is still required, even when applicant is deemed not feasible for vocational retraining and is permanently and totally disabled as a result. (*Ibid*.) In such cases, the WCJ must determine whether the cause of the permanent and total disability includes nonindustrial or prior industrial factors, or whether the permanent disability reflected in applicant's inability to meaningfully participate in vocational retraining arises solely out of the current industrial injury. (*Ibid*.) We subsequently re-affirmed these principles in *Nunes v. State of California, Dept. of Motor Vehicles* (*Nunes II*) (2023) 88 Cal.Comp.Cases 894 (Appeals Bd. en banc).

Defendant contends that VE Wilson "impermissibly ignores valid apportionment given by AME Dr. Hyman in contravention of Nunes[.]" (Petition, p. 17.) Defendant, however, provides no evidence to support this allegation. As demonstrated by her initial report, and all her subsequent reports, various medical records, including the medical reports of Dr. Hyman were reviewed and taken into consideration in the preparation of her vocational expert opinions. (Exhibits 6-11.) Accordingly, we agree with the WCJ that the reports of VE Wilson constitute substantial evidence.

IV.

Defendant contends that the "*Almaraz Guzman*" ratings provided by Drs. Fedder and Hyman are not substantial medical evidence. (Petition, p. 2.)

Defendant's argument, however, misses the point as applicant has already successfully rebutted the PDRS through VE Wilson's reporting. Nonetheless, we address the issue of the applicability of the addition versus CVC method for rating impairments.

In *Athens Administrators v. Workers' Comp. Appeals Bd.* (*Kite*) (2013) 78 Cal.Comp.Cases 213 (writ den.), the Appeals Board held that if there is substantial medical evidence that two or more impairments have a synergistic effect which causes the resulting impairment to be greater than that reflected through use of the CVC, the impairments should be added for purposes of accuracy. In *Kite*, the applicant underwent bilateral hip replacement surgeries and the orthopedic QME opined that due to a "synergistic effect of the injury to the same body parts bilaterally versus body parts from different regions of the body," "the best way to combine the impairments to the right and left hips would be to add them versus using the combined values chart, which would result in a lower whole person impairment." *(Id*. at p. 5.) Accordingly, the WCJ in *Kite* found that the impairment for the applicant's hips should be added rather than combined.

Subsequent to *Kite*, the Appeals Board issued its en banc decision in *Vigil v. County of Kern* (2024) 89 Cal.Comp.Cases 686, 688-689 (Appeals Bd. en banc) wherein it was determined that if an applicant seeks to rebut the CVC and add rather than combine impairments, the applicant must establish 1) The activities of daily living (ADLs) impacted by each impairment, and 2) That the ADLs either do not overlap, or overlap in such a way that it increases or amplifies the impact of the overlapping ADLs.

Here, in a report dated January 7, 2026, Dr. Hyman reiterated that due to "narcotic induced constipation" applicant sustained an 8% WPI for GERD with 40% apportionment to work, and with respect to applicant's deconditioning, hypertension, and coronary artery disease, applicant sustained 15%, 30%, and 35% WPI, respectively, with apportionment divided 100%, seventy percent (70%) and forty-five percent (45%) to the cumulative injury. (Exhibit BBB, p. 1.) In an earlier report dated November 12, 2025, Dr. Hyman opined as follows with respect to use of the addition versus CVC method for rating impairment:

> Relating to the issue of Vigil, his internal medicine problems should be additive rather than combined with any orthopedic or psychological issues as they impact his impairment in different ways.
>
> Concerning his internal medicine conditions, his gastrointestinal and heart problems would be considered additive as they impact impairment differently and are synergistic.
>
> All gastrointestinal problems should be combined affecting impairment similarly. This is true also of his deconditioning, coronary artery disease and hypertension which should be combined because they all affect functioning of the cardiovascular system.

(Exhibit YY, p. 4.)

Dr. Hyman documented applicant's various limitations to ADLs during the life of applicant's claims. In a report dated November 12, 2025, he indicated as follows regarding applicant's GERD:

> He continues to have narcotic induced constipation without a bowel movement for up to four days but he does not do anything about it and is asymptomatic.

(Exhibit YY, p. 2.)

Dr. Hyman also documented the following limitations related to applicant's deconditioning, coronary artery disease, and hypertension:

> He occasionally has mild chest pain. He is able to walk ¼ of a mile in 25 minutes which he does daily and is primarily limited by orthopedic problems. However, if he walks up an incline he becomes short of breath.
>
> He sleeps on reclining bed at 25 degrees. He doesn't wake up short of breath and gets up three to four times to urinate. He has no ankle swelling or palpitations. He is postural because of his blood pressure medications.

Lastly, he provided a summary of applicant's ADLs:

> He has no trouble with sensory function but has difficulty dressing. The quality of his writing has deteriorated. He can stand for 10 minutes, sit for 20 minutes, walk for 5 minutes without pain and has trouble climbing stairs.
>
> He can lift 20 pounds with either hand and has no loss of tactile discrimination. He can drive for 60 minutes. Erectile dysfunction interferes with sexual activity and has not been benefited by a variety of treatments.
>
> He takes nothing to sleep and falls asleep in 15 minutes. He gets up three to four times and goes back to sleep in 10 minutes. He gets six hours of sleep a night and naps daily for 60 to 90 minutes. No snoring or apnea is noted. He had a negative sleep study in the past. However, his Epworth score is 12.

(*Id.* at pp. 2-3.)

Similarly, Dr. Fedder in his report dated March 8, 2019, opined that "[i]n view of the multilevel orthopedic involvement in the upper and lower extremities, as well as the neck and back, in view of the multiple surgical procedures [applicant] has had…there is a synergistic effect between all the areas of orthopedic injury" such that impairments should be "added rather than combined." (Exhibit HH, p. 91.) Dr. Fedder further indicated that applicant sustained an overall 75% WPI for this orthopedic claims upon addition of the following: 5% WPI to cervical spine under DRE category II and limitations to activities of daily living, 31% WPI to the lumbar spine (16% WPI from loss of range of motion, 15% WPI from a specific spine disorder caused by a two level fusion surgery, and a 2% pain add-on), 8% WPI and 9% WPI to the left and right upper extremities from loss of range of motion and diagnostic studies documenting carpal tunnel, 20% WPI to the left hip from surgery, 7% WPI to the left lower extremity from gait derangement, and 1% WPI to the right lower extremity from DBE. (*Id*. at pp. 89-91.) Regarding specific ADLs, Dr. Fedder noted the following:

> With regard to the cervical spine, this patient is complaining of constant mild 2/10 discomfort across the base of the neck into the left upper shoulder and not in the

right upper shoulder. His neck does not feel stiff. Motion of the cervical spine will bother him “a little bit/minor.” That would be a 3/10.

This man indicates that lifting, carrying, pushing or pulling a 20-pound bag of dog food will not bother his neck. He limits his lifting to 20-pounds primarily because of his lower back.

There is no radiating pain to either upper extremity. There is intermittent numbness in the left hand involving the dorsum of the left hand, as well as the palmar aspect of the left hand. There is no tingling in the left upper extremity or hand. There is no numbness and tingling in the right upper extremity or hand. His left arm is “a little” weak. He notes “a little” loss of grip strength in the left hand. He does not drop things from the left hand. The right arm does not feel weak. He has not lost grip strength in the right hand. He does not drop things from the right hand.

With regard to his shoulders, he indicates his complaints have been in the upper shoulder areas, left side diminished since the ablation, and the right side is still minor. He indicates, “They were going to do a test ablation on my right side, but after all the pain with the left ablation on the left side, I declined."

This man denies any stiffness in either shoulder. His shoulders do not lock, sublux or dislocate.

Motion of the arms below the horizontal does not cause discomfort in either shoulder, but a little stiffness in the left upper shoulder. Working with the arms at shoulder level does not bother his shoulders. He has difficulty raising his arms overhead because that results in pain in the upper shoulder areas, left side more than right. Lifting, carrying, pushing or pulling a 20-pound bag of dog food does not bother his shoulders.

This man's doctors have not recommended surgery on his shoulders. They have not recommended surgery on his neck. They are no longer mentioning cervical epidural steroid injections. In the past, the patient declined them because of the diabetic situation.

To relieve complaints in the neck and upper shoulders, this man uses ibuprofen three times a day.

With regard to the left elbow, this man has no complaints. The left elbow does not feel stiff or lock. The left elbow does not sublux or dislocate. Flexion and extension of the left elbow does not cause discomfort. Forceful torqueing [sic] does not bother the left elbow. Gripping and squeezing does not bother his left elbow. Lifting, carrying, pushing or pulling does not bother his left elbow.

With regard to the wrists and hands, there are no complaints. The wrists do not feel or lock. His fingers do not feel stiff or trigger. Motion of the wrists does not cause

discomfort. Gripping and squeezing does not bother his wrists or hands. Lifting, carrying, pushing or pulling does not bother his wrists or hands.

This man does have numbness in the palmar and dorsal aspect of his left hand, not the fingers or wrist. There is no numbness and tingling in the right wrist or fingers.

This man has not had recent treatment for the left elbow or wrist. At this point, he does not feel in need of that care.

This patient's primary orthopedic problem is in his lower back with radiating pain to the left hip, buttock and posterior proximal half of the left thigh. Repetitive bending will cause 5-6/10 complaints to the low back. He is unable to do prolonged stooping because that would cause 7-8/10 pain in the lower back. The low back pain is in the midline from L4 to the sacrum. It does not affect the lumbar paravertebral muscles. Lifting, carrying, pushing or pulling a 20-pound bag of dog food will cause 7-8/10 pain in the lower back.

There is intermittent radiating pain to the left buttock and proximal half of the posterior left thigh. There is no radiating pain to the right lower extremity. He denies numbness and tingling in the left lower extremity or foot. There is no numbness and tingling in the right lower extremity or foot. His left leg feels weak. He indicates he has noted atrophy of the left thigh and calf. When asked if the left leg has given out on him causing him to fall, he indicates that the falls that he has had are due to loss of balance. He has not noted weakness in his right lower extremity. His right leg has not given way causing him to fall. There has been no bowel or bladder incontinence.

This man relates that since I last examined him, he did have a spinal cord stimulator placed in 2017. That was followed by a permanent spinal cord stimulator, which remains in place. He continues to have follow up care for that device at UC Davis Hospital. He does not wear a back support, but he does carry a cane primarily for pain in the left hip on an as needed basis. He carries a cane about three times a week. He does back stretching exercises as directed by the physical therapist twice a week. As noted, he does have a permanent spinal cord stimulator in place, which he finds to be of significant benefit. His doctors are not recommended lumbar epidural steroid injections or additional lumbar spinal surgery.

When asked if he has pain in the left hip itself, he answers, “it's a radiating pain.”

With regard to his knees, at this point, he indicates only the right knee continues to bother him. His left knee does not bother him anymore.

The right knee pain is a constant 2/10 in the patellofemoral articulation. His right knee does not feel stiff or lock. His right knee does not buckle or feel weak. It has not caused him to fall. Prolonged standing or walking will cause 4/10 discomfort in the right knee. Repetitive ascending or descending of stairs will cause 7 /10 pain

> in the right knee. He avoids squatting and kneeling because it would cause 10/10 pain in the right knee.
>
> This man indicates in order to relieve the pain in the right knee, he has to keep it "out straight." He does not walk with a straight leg. While sitting or lying down, he keeps his right knee straight.
>
> With regard to the 1eft knee, there has been no recent discomfort. He does not use a knee support on either knee. He is not using the cane for problems with his knees.

(*Id*. at pp. 78-82.)

Dr. Fedder also provided the following summary:

> With regard to activities of daily living, this man has slight problems with standing and minimal difficulty sitting. He has moderate problems with going up and down stairs. He indicates he can lift and carry light to medium objects. He only walks short distances. The most strenuous activity he can do for two minutes is light activity. He has a lot of difficulty climbing a flight of stairs. He can sit 30-60 minutes at a time. He can stand and walk 15-30 minutes at a time. He has a lot of difficulty reaching for something on a shelf overhead with both shoulders. He has no difficulty with gripping, grasping; or manipulating objects with his hands. He has difficulty with repetitive motion, such as typing on a computer. He has no difficulty with forceful activity with his arms and hands. He is unable to bend, kneel or squat. His pain at the moment is moderate and his pain most of the time is moderate. Average pain during the past week is a 4/10 and worst pain during the past week was an 8/10. His worst pain is in the low back.

(*Id*. at p. 81.)

Based the foregoing, and the totality of the evidence, including the reports of Drs. Hyman and Fedder, we agree with the WCJ that the requirements outlined under *Vigil* have been satisfied and that applicant has successfully rebutted the CVC.

V.

Lastly, defendant argues that applicant' occupational group number should be 212 based upon applicant's deposition testimony and statements made by applicant to doctors regarding job duties. (Petition, p. 2.)

An employee's occupation is one of the component parts for rating permanent disability. The reason for this is that it serves to "aid in determining the relative effects of disability to various parts of the body taking into account the physical requirements of various occupations." (*Holt v. Workers' Comp. Appeals Bd.* (1986) 187 Cal.App.3d 1257, 1261 [51 Cal.Comp.Cases 576].) For

injuries occurring before January 1, 2013, rating is completed through the 2005 Permanent Disability Rating Schedule (PDRS) which contains 45 occupational group numbers (Lab. Code, § 4660.1; 2005 PDRS, pp. 1-8.) Which occupational group number is to be applied in each case is a question of fact to be determined by the trier of fact. (*Dalen v. Workmen's Comp. Appeals Bd.* (1972) 26 Cal.App.3d 497, 503 [37 Cal.Comp.Cases 393].) It is also well established that an "employee is entitled to be rated for the occupation which carries the highest factor in the computation of disability." (*Id.* at pp. 505-506.) However, there must be evidence that the employee in fact performed the duties required of the more arduous occupation. (*Holt, supra* at 1257.) An employee may also be entitled to a higher occupational group number if the activity (or activities) which generates the higher occupational group is an integral part of the occupation. (*National Kinney v. Workers' Comp. Appeals Bd.* (Casillas) (1980) 113 Cal.App.3d 203, 215-216 [45 Cal.Comp.Cases 1266].)

Here, applicant testified during trial that he worked as both a plant manager (occupational group 212) and an associate warden (occupational group 490) during the injury dates. (Minutes of Hearing and Summary of Evidence (MOH/SOE), January 30, 2024, pp. 9-10.) According to applicant's unrebutted testimony, starting in 2004, he worked as an associate warden on a rotational basis working approximately one week every two months. (*Id*. at p. 9.) As an associate warden, he was required to "maintain his peace officer standards" including firearms training, which was initially a one-time two-week training, but ultimately became a 40-hour per year training. (*Ibid*.) Given that applicant's work as an associate warden was an integral part of his occupation and was not rebutted by defendant, he is entitled to a higher occupational group number of 490.

We further note that the WCJ found applicant's testimony regarding his work as an associate warden to be credible. (Report, p. 2.) Credibility determinations of the WCJ, as the trier of fact, are entitled to great weight based upon the WCJ's opportunity to observe the demeanor of the witnesses and weigh their statements in connection with their manner on the stand. (*Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312, 318-319 [35 Cal.Comp.Cases 500].) A WCJ's credibility determination may be disturbed only where there is contrary evidence of considerable substantiality. (*Ibid*.) No such evidence was provided here. As such, there is no reason to disturb the WCJ's assignment of applicant to occupational group 490.

Accordingly, defendant's Petition is denied.

For the foregoing reasons,

IT IS ORDERED that defendant's Petition for Reconsideration of the workers compensation administrative law judge's Joint Findings, Award, and Order issued on May 7, 2026, is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSEPH V. CAPURRO, COMMISSIONER

I CONCUR,

/s/ CRAIG L. SNELLINGS, COMMISSIONER

/s/ JOSÉ H. RAZO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

AUGUST 14, 2026

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

WAYNE DAVISON
MALLERY & STERN, APC
STATE COMPENSATION INSURANCE FUND

RL/*cs*

I certify that I affixed the official seal of the Workers' Compensation Appeals Board to this original decision on this date.
CS