WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

JOSE LUIS VALENCIA, ***Applicant***

vs.

ENTERPRISE RENT-A-CAR COMPANY OF LOS ANGELES, LLC; TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA, administered by SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., ***Defendants***

Adjudication Number: ADJ13633820
Van Nuys District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

Defendant seeks reconsideration of the Findings of Fact and Order (F&O) issued on June 19, 2026, by the workers' compensation administrative law judge (WCJ). The WCJ found, in pertinent part, that applicant sustained 100% permanent disability.

Defendant contends that the reporting of applicant's vocational expert, Enrique Vega, M.S., does not constitute substantial evidence because he relied on work restrictions and functional limitations not included in the reports of the Panel Qualified Medical Evaluator (PQME) Vlad Gendelman, M.D., and rendered medical opinions reserved for a physician.

Defendant further asserts that the record requires development because PQME Dr. Gendelman did not review the vocational reports and that the reporting of its vocational expert, Nick Corso, M.A., constitutes substantial evidence.

We have not received an Answer from applicant. The WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending that we deny reconsideration.

We have considered the allegations in defendant's Petition and the contents of the WCJ's Report. Based on our review of the record, and for the reasons discussed below, we will deny the Petition for Reconsideration.

FACTS

I.

The parties stipulated that applicant, while employed as a driver during the period April 16, 2019 to April 16, 2020, sustained injury arising out of and in the course of employment (AOE/COE) to his bilateral shoulders, right knee and right foot and claimed to have sustained injury AOE/COE to his neck, thoracic and lumbar spine, bilateral elbows and left knee. (Minutes of Hearing and Summary of Evidence (MOH/SOE), 05/21/2025, 2:5-9.)

The parties proceeded to trial on May 21, 2025 for the WCJ to adjudicate the additional body parts that applicant claimed he injured.

Applicant submitted into evidence the PQME reports and depositions of Dr. Gendelman (App. Exs. 1-9, 15-16) as well as the vocational expert reports of Mr. Vega. (App. Exs. 13-14.) Defendant submitted into evidence the vocational testing report of Paulo R. Da Silva, B.A. dated August 27, 2024 (Def. Ex. L) and the vocational expert reports of Mr. Corso. (Def. Exs. M, O-P.)

On September 2, 2025, the WCJ issued a Findings and Award, finding, in relevant part, that applicant sustained injury AOE/COE to his bilateral shoulders, bilateral knees, right foot, cervical spine, thoracic spine, lumbar spine, and bilateral elbows. The WCJ based his decision on the PQME reports of Dr. Gendelman, found to be substantial medical evidence. The WCJ awarded applicant benefits consistent with his findings. Applicant filed no petition for reconsideration, and the WCJ's opinion became final.

On March 26, 2026, the case returned to the trial calendar, where the parties stipulated that that defendant's private rating calculated with apportionment yielded 69% permanent disability, while the rating without apportionment yielded 72% after adjustment for age and occupation, and that the Disability Evaluation Unit (DEU) rating was 75%. Applicant contended that he is 100% permanently and totally disabled, relying on the PQME and vocational rehabilitation reporting. (Minutes of Hearing (MOH), 03/26/2026, 2:6-13.) The issue before the WCJ concerned the proper rating of applicant's permanent disability. (MOH, 03/26/2026, 2:15-16.)

On June 19, 2026, the WCJ issued his F&O finding that applicant sustained 100% permanent disability.

In his Opinion on Decision, the WCJ found Mr. Vega's opinions on permanent disability more persuasive than Mr. Corso's.

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

II.

During the period from July 1, 2026 to July 13, 2026, Labor Code section 5909(a)[1] 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(a).)

Here, the Petition for Reconsideration was filed on July 13, 2026, and 60 days from the date of filing is September 11, 2026. This decision is issued by or on September 11, 2026, so that we have timely acted on the petition as required by section 5909(a).

III.

Turning to the merits, defendant asserts that the record does not support the findings of the WCJ as to permanent total disability. On April 22, 2021, PQME Dr. Gendelman evaluated applicant, documenting subjective complaints of radiating neck pain along with back pain rated at 8-9/10 into his legs, episodic swelling, numbness, and tingling, increased symptoms with prolonged standing, walking, sitting, driving, lifting, pushing, pulling, and reaching, and difficulty sleeping. He reported an inability to sit or stand for more than approximately 30 minutes before his symptoms increased. He reported right shoulder pain rated at 7/10 and left shoulder pain rated at 8/10, both accompanied by clicking, radiation into his arms, numbness, and tingling that worsens with overhead activities, lifting, pushing, and pulling. (App. Ex. 1, pp. 4-5.) He also reported intermittent left elbow pain rated at 5/10, as well as continuous bilateral wrist and hand pain, rated at 7/10 on the left and 4–5/10 on the right, with sharp pain radiating into the fingers and thumb pain aggravated by pressure and bending. He reported bilateral hand weakness, with numbness and tingling in the left hand and wrist and several instances of dropping objects. Gripping, grasping, flexing, extending, rotating, and repetitive hand and finger movements increased his pain. (*Id.* at p. 5.) Finally, he reported continuous bilateral knee pain, rated at 7/10 on the left and 8-9/10 on the right, with clicking and instability, including episodes in which the right knee gives way and affects his gait. He also reported bilateral foot pain rated at 7-8/10, with swelling, numbness, and bunions. He stated that these symptoms limited his ability to walk, stand, kneel, squat, and ascend or descend stairs. (*Id.* at pp. 5-6.)

The cervical examination revealed bilateral paraspinal guarding, trapezius tenderness and spasm, and restricted range of motion (ROM), measuring 36° flexion (50° normal), 41° extension

[1] Unless otherwise stated, all further statutory references are to the Labor Code.

(60° normal), 36° right lateral flexion (45° normal), 32° left lateral flexion (45° normal), 60° right rotation (80° normal), and 63° left rotation (80° normal). (*Id.* at p. 7.)

The thoracic examination revealed guarding, tenderness, and spasm, with flexion measuring 41° (50° normal), right rotation 19° (30° normal), and left rotation 18° (30° normal). (*Ibid.*)

The lumbar examination revealed bilateral paraspinal, sacroiliac, and sciatic-notch tenderness, paraspinal spasm, and restricted range of motion (ROM), measuring 34° flexion (60° normal), 13° extension (25° normal), 15° right lateral flexion (25° normal), and 17° left lateral flexion (25° normal). Straight-leg raising tests were negative bilaterally, and applicant was able to walk on his heels and toes. (*Id.* at p. 8.)

The shoulder examination revealed well-healed arthroscopic portals over the right shoulder from a October 2019 arthroscopic surgery, with right shoulder flexion and abduction each measuring 100° and left shoulder flexion measuring 140° and abduction 120°, compared with an estimated normal of 180°. Neer's, Hawkins', and lateral Jobe's impingement tests were positive bilaterally. (*Id.* at pp. 8-9, 17.) Motor testing showed 4/5 strength in the right shoulder with flexion, abduction, extension, adduction, internal rotation, and external rotation, compared with 5/5 strength for the corresponding movements on the left. Sensation remained intact throughout the upper extremities. (*Id.* at p. 12.)

The knee examination revealed flexion measuring 120° on the right (150° normal) and 125° on the left (150° normal), with a positive right patellofemoral grind test. (*Id.* at p. 13.) The right knee demonstrated 4/5 strength in flexion and extension, while motor testing of the remaining lower extremities demonstrated 5/5 strength. Sensation remained intact throughout the lower extremities. (*Id.* at p. 16.)

PQME Dr. Gendelman diagnosed cervical, thoracic, and lumbosacral musculoligamentous strain/sprain; bilateral shoulder impingement; residual right shoulder pain and weakness following surgery; bilateral lateral epicondylitis; bilateral wrist/hand strain; bilateral knee pain; and bilateral foot pain. He attributed these conditions to the cumulative trauma injury from April 16, 2019 to April 16, 2020. (*Id.* at p. 17.)

In his supplemental report dated August 9, 2021 PQME Dr. Gendelman reviewed an MRI of the left shoulder interpreted by Fariborz Kharrazi, M.D., dated July 29, 2020 documenting a large full-thickness supraspinatus tear, chronic partial-thickness infraspinatus tearing, muscle

atrophy, retraction to the glenohumeral joint, a superior-labral tear, biceps pathology, and acromioclavicular degenerative changes. (App. Ex. 3, pp. 1-2.) PQME Dr. Gendelman also reviewed an operative report by Daniel Kharrazi, M.D., dated October 16, 2020 documenting a massive retracted irreparable right rotator cuff tear and included synovectomy, debridement, bursectomy, acromioplasty with a Mumford/distal clavicular resection, and debridement of the irreparable tear. (*Id.* at pp. 2-3.)

In his supplemental report dated November 23, 2021, PQME Dr. Gendelman reviewed an MRI of the left knee by Michael Im, M.D., dated November 19, 2021 documenting a high-grade cartilage fissure involving the medial and central patella, a small effusion, and a 0.8 cm calcified intra-articular body. (App. Ex. 4, p. 2.)

In his supplemental report dated February 3, 2022, PQME Dr. Gendelman reviewed an August 19, 2021 MRI of the cervical spine interpreted by Siamak Dardashti, M.D., which showed multilevel degenerative disc disease and osteophytic changes with foraminal narrowing and mild-to-moderate stenosis. (App. Ex. 5, pp. 1-2.) He also reviewed an August 20, 2021 MRI of the lumbar spine interpreted by Dr. Dardashti, which showed severe L5-S1 disc-space narrowing, a 3 mm posterior disc bulge, and moderate-to-severe bilateral neural foraminal narrowing. (*Id.* at p. 2.) PQME Dr. Gendelman further reviewed a November 24, 2021 MRI of the right shoulder interpreted by Daniel Amirhamzeh, M.D., which showed a large full-thickness tear of the supraspinatus and infraspinatus with substantial medial retraction, secondary superior migration of the humeral head, and associated fatty muscular atrophy. The MRI also showed subscapularis tendinosis with a low-grade partial-thickness tear, pathology involving the long head of the biceps tendon, superior labral degeneration, and mild-to-moderate osteoarthrosis of the glenohumeral and acromioclavicular joints. (*Id.* at pp. 3-4.)

In his reevaluation report dated October 14, 2022, PQME Dr. Gendelman recorded applicant's reports of neck pain at 5/10; continuous low back pain radiating into the legs at 6/10; right shoulder pain at 6/10; left shoulder pain at 4–5/10; bilateral elbow pain at 4/10; right knee pain at 6–7/10; left knee pain at 2/10; right foot pain at 5/10; and left foot pain at 4/10. He continued to report difficulty with prolonged standing, walking, and sitting, as well as reaching, pushing, pulling, lifting, kneeling, squatting, stair climbing, and driving. (App. Ex. 6, pp. 3-5.) His activities of daily living questionnaire reflected moderate interference with various self-care, sensory, physical, travel, sexual, exercise, and sleep-related activities, including bathing, dressing,

grooming, neck movement, overhead work, walking, standing, lifting, carrying, pushing, pulling, driving, sexual activity, exercise, and restful sleep. (*Id.* at p. 5.)

Cervical motion measured 36° of flexion (50° normal), 42° of extension (60° normal), 34° of right lateral flexion (45° normal), 33° of left lateral flexion (45° normal), 62° of right rotation (80° normal), and 64° of left rotation (80° normal). (*Id.* at p. 6.) The thoracic examination documented guarding, tenderness, and spasm, with flexion of 42° (50° normal) and bilateral rotation of 20° (30° normal). (*Id.* at p. 7.) Lumbar motion measured 36° of flexion (60° normal), 11° of extension (25° normal), and 16° of right (25° normal) and left lateral flexion (25° normal). Supine straight-leg raising was positive at 55° on the right and 60° on the left, although seated straight-leg raising remained negative and applicant was able to walk on his heels and toes. (*Id.* at p. 8.)

The shoulder examination showed persistent bilateral tenderness and restricted range of motion (ROM), with right shoulder flexion measuring 110° (180° normal) and left shoulder flexion measuring 150° (180° normal). Right shoulder abduction measured 90° (180° normal), while left shoulder abduction measured 120° (180° normal). (*Id.* at pp. 8-9.) Neer's, Hawkins', and lateral Jobe's tests were positive bilaterally. (*Id.* at p. 9.) Motor testing demonstrated 4/5 strength in the right shoulder and right elbow. (*Id.* at p. 12.) The examination also revealed bilateral elbow tenderness and a positive Cozen's test. (*Id.* at p. 9.) The right knee demonstrated flexion of 120° (150° normal) and the left knee flexion of 125° (150° normal), with 4/5 strength in right knee flexion and extension. (*Id.* at pp. 12, 15.) Sensation remained intact throughout the lower extremities. (*Id.* at p. 15.)

PQME Dr. Gendelman imposed work restrictions for cervical spine activities by precluding repetitive flexion or extension of the head and neck, neck bending, and prolonged overhead work. For the lumbar spine, the restrictions preclude heavy to substantial work and activities involving comparable physical effort, including bending, stooping, lifting, pushing, pulling, and climbing. The right shoulder restrictions preclude heavy lifting, repetitive flexion and abduction, and work at or above shoulder level, while the left shoulder restrictions preclude heavy lifting, repetitive flexion and abduction, and repetitive work at or above shoulder level. The bilateral elbow restrictions preclude repetitive pulling or pushing and other stressful activities. The right knee restrictions preclude prolonged climbing, walking over uneven ground, squatting, crouching, crawling, pivoting, and other weight-bearing activities, while the left knee restriction preclude

walking over uneven ground and reflect an approximately 90 to 100% loss of ability to walk over rough terrain. (*Id.* at p. 26.)

PQME Dr. Gendelman assigned 8% whole person impairment (WPI) for the cervical spine based on clinical findings of decreased ROM, muscle spasm, and abnormal MRI findings. (AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), Table 15-5, (Diagnosis-related estimate (DRE) Category II, p. 392.) (*Id.* at pp. 27-28.) He assigned 5% WPI for the thoracic spine based on objective evidence of decreased ROM and paravertebral muscle spasms in the thoracic spine (AMA Guides, Table 15-4, DRE Category II, p. 389) and 13% WPI for the lumbar spine based on demonstrated decreased motion, positive straight leg raising, abnormal MRI findings, and sensory loss. (AMA Guides, Table 15-3, DRE Category III, p. 384.) (*Id.* at pp. 27-28.)

For the upper extremities, he calculated a 23% upper extremity (UE) impairment for the right shoulder by aggregating by Combined Values Chart (CVC) (AMA Guides, p. 604) 13% UE impairment for loss of motion (5% flexion, 1% extension, 2% internal rotation, 0% external rotation, 4% abduction and 1% adduction) (AMA Guides, Figure 16-40, p. 476; Figure 16-43, p. 477; Figure 16-46, p. 479) with 11% UE impairment for strength deficit (5% flexion, 1% extension, 2% abduction, 1% adduction, 1% internal rotation and 1% external rotation) (AMA Guides, Table 16-35, p. 510.) (*Id.* at p. 29.) He calculated 14% UE impairment for the right elbow based on strength deficit (4% flexion, 4% extension, 3% pronation and 3% supination) (AMA Guides, Table 16-35, p. 510), then combined by CVC the shoulder and elbow values to 34% right UE impairment and converted that to 20% WPI. (AMA Guides, Table 16-3, p. 439.) (*Id.* at pp. 29-30.)

He calculated 8% UE impairment for the left shoulder based on loss of ROM. (2% flexion, 1% extension, 1% internal rotation, 0% external rotation, 3% abduction, and 1% adduction.) (AMA Guides, Figure 16-40, p. 476; Figure 16-43, p. 477; Figure 16-46, p. 479.) He calculated 14% UE impairment for the left elbow based on strength loss. (4% flexion, 4% extension, 3% pronation, and 3% supination.) (AMA Guides, Table 16-35, p. 510.) He then reported that combining the shoulder and elbow impairments using the CVC resulted in 22% left UE

impairment, which he converted to 13% WPI. (AMA Guides, Table 16-3, p. 439.)[2] (*Id.* at pp. 30-31.)

For the right knee, he assigned 5% WPI for Grade 4 flexion weakness and 5% WPI for Grade 4 extension weakness, (AMA Guides, Table 17-7, p. 531; Table 17-8, p. 532) combining them by CVC to yield 10% WPI. He assigned 0% WPI to the left knee and bilateral feet.

He combined by CVC 8% WPI for the cervical spine, 5% WPI for the thoracic spine, 13% WPI for the lumbar spine, 20% WPI for the right upper extremity, 13% WPI for the left upper extremity, and 10% WPI for the right knee to yield an unapportioned award of 52% WPI. (*Id.* at pp. 25, 31-32.)

In his February 16, 2023 deposition, PQME Dr. Gendelman expressly agreed that he needed to change his rating methodology. (App. Ex. 15, p. 20:12-16.) He stated that the operative report by Dr. Kharrazi dated October 16, 2020 showed a distal clavicle resection not previously rated and failed to identify the verifiable radiculopathy needed to support Lumbar DRE Category III. (*Id.* at pp. 20:17-25 to 21:1-3.) PQME Dr. Gendelman stated that the multilevel MRI findings led him to consider the ROM method and that, if the DRE method remained applicable, the lumbar spine would have to fall into Category II rather than Category III. (*Id.* at pp. 21:4-25 to 22:1-7.)

He also stated that the AMA Guides require calculation under both the DRE and ROM methods when both methods apply, with the higher rating selected. (*Id*. at pp. 22:21-25 to 23:1-22.)

In his supplemental report dated March 22, 2023, PQME Dr. Gendelman replaced the Lumbar DRE Category III rating with a dual method analysis. (App. Ex. 7, p. 7.) He stated that DRE Category III rating was incorrect because the records contained complaints of radiculopathy but no provocative or neurologic testing that clinically verified radiculopathy. (*Id.* at p. 6.) He concluded that DRE Category II was the appropriate classification and assigned 8% WPI (AMA Guides, Table 15-3, p. 384), based on persistent residuals, limited motion, guarding, and lumbar paraspinal spasm. (*Id.* at p. 7.)

He then applied the ROM method based on the multilevel lumbar involvement and history of more than one lumbar injury, explaining that the AMA Guides permit him to calculate

[2] The 22% left UE impairment reported by PQME Dr. Gendelman does not appear to correspond to the CVC calculation. Combining 8% left shoulder impairment with 14% left elbow impairment yields 21%, rather than 22%, although both 21% and 22% UE impairments convert to 13% WPI.

impairment under both the ROM and DRE methods and select the higher result. (AMA Guides, § 15.2, p. 380.) (*Id*. at p. 7.) He calculated 4% WPI for loss of flexion, 5% WPI for loss of extension, 2% WPI for loss of right lateral flexion, and 2% WPI for loss of left lateral flexion, resulting in 13% WPI for lumbar motion loss. (AMA Guides, Table 15-8, p. 407; Table 15-9, p. 409.) (*Id.* at pp. 7-8.) He also calculated 7% WPI for the L5-S1 specific spine disorder and 1% WPI for each of three additional levels, resulting in 10% WPI for the specific spine disorder component. (AMA Guides, Table 15-7, Section II(C) and (F), p. 404.) He then combined the 13% WPI motion component with the 10% WPI specific spine disorder component using the CVC, totaling 22% WPI for the lumbar spine. He therefore selected 22% WPI under the ROM method rather than 8% WPI under DRE Category II. (*Id.* at p. 8.)

PQME Dr. Gendelman further corrected the WPI for the right shoulder stating that the original 23% UE impairment combined 13% UE impairment for ROM loss and 11% UE impairment for strength deficit, but failed to include the distal clavicle resection. He assigned 10% UE impairment for the distal clavicle resection arthroplasty. (AMA Guides, Table 16-27, p. 506.) He therefore described a combined 31% UE impairment calculation, yet immediately thereafter converted the previously stated 23% UE impairment figure to 14% WPI (AMA Guides, Table 16-3, p. 439) as the corrected right shoulder impairment rather than 19% WPI. (*Id.* at p. 9.)

In his deposition dated August 10, 2023, when questioned about the AMA Guides' language concerning acute muscle spasm and ROM measurements, PQME Dr. Gendelman stated that the paraspinal spasm he observed during his October 14, 2022 evaluation was chronic rather than an acute exacerbation and, therefore, in his opinion, did not preclude use of the ROM method. (App. Ex. 16, pp. 40:8-25 to 42:1-4.) He reiterated that he selected the ROM method based on the history of more than one lumbar injury and the multilevel abnormalities shown on the MRI. (*Id.* at pp. 43:13-20.)

He further considered the 10% WPI specific spine disorder component to represent pathology that the ROM loss did not capture. (*Id.* at p. 44:16-23.) He stated that the MRI disc bulges did not reduce lumbar motion sufficiently to account for the entire impairment and that the reduced motion instead resulted from inflammation and spasm of the paraspinal musculature. (*Id.* at pp. 44:24-25 to 45:1-7.)

He explained that 10% UE impairment for the distal clavicle resection came directly from the applicable table in the AMA Guides and stated that, in his view, the procedure itself did not

materially affect manual strength testing. (*Id.*at pp. 51:24-25 to 54:1-7.) He further stated that a physician could perform strength and ROM testing despite limited motion if they positioned the shoulder correctly. (*Id.* at p. 51:8-18.)

In his supplemental report dated August 16, 2023, PQME Dr. Gendelman reiterated his calculations of 13% WPI ROM component, 10% WPI for the specific spine disorder component, 0% WPI for the nerve root component, and the resulting 22% WPI. He also stated that the disc bulges did not significantly reduce motion and that the motion loss resulted from paraspinal inflammation and spasm. (App. Ex. 8, pp. 8-9.)

In his supplemental report dated April 16, 2024, PQME Dr. Gendleman added that the strength deficit percentage used for the bilateral elbows was Grade 4 (25%) (AMA Guides, Table 16-35, p. 510.) (App. Ex. 9, p. 7.)

Turning to the vocational evidence, Mr. Vega issued a vocational evaluation report dated March 25, 2024, in which he recorded that applicant completed the 10th or 11th grade in Mexico but did not graduate for economic reasons. Applicant attended English as a Second Language (ESL) classes for six months before leaving school to pursue employment and has no other formal education. (App. Ex. 13, p. 6.)

In the cognitive and comprehension assessments, applicant scored 43 on the Beta 4 assessment, which corresponds to a Beta intelligence quotient of 90, placing him in the 25th percentile and the low average range for non-verbal intellectual functioning. (*Id.* at p. 10.) The Wide Range Achievement Test, Fifth Edition, established average word reading and math computation abilities, but low average spelling, sentence comprehension and reading composite abilities, suggesting that he has low average English proficiency with difficulty spelling words. (*Id.* at p. 8.) The Adult Basic Learning Examination Spanish Reading Tests placed his Spanish reading comprehension at a fifth grade level and problem solving at a sixth grade level. Applicant failed to complete either Spanish assessment section within the allotted time, indicating deficits in concentration, persistence, and pace. (*Id.* at p. 10.) The Minnesota Clerical Test measured "low-mid" numerical aptitude and below average name comparison aptitude. (*Id.* at p. 9.)

In the physical and dexterity tests, the Dvorine Color Vision Test confirmed normal color vision. (*Id.* at pp. 7-8.) The Purdue Pegboard Test, Bennett Hand-Tool Dexterity Test, and Minnesota Rate of Manipulation Tests all yielded very low scores, establishing poor manual and finger dexterity. (*Id.* at pp. 8-9.) During the tests, Mr. Vega observed applicant exhibiting visible

hand tremors, shifting continuously between sitting and standing positions due to pain, demonstrating a slow work pace, and expressing complaints of right hand fatigue and neck pain. (*Id.* at pp. 9-10.)

Applicant reported severe subjective symptoms, including continuous neck pain with movement and constant back pain radiating into his leg. He rated his baseline pain at 8-9/10, decreasing to 5-6/10 with medication. (*Id.* at p. 5.) He described significant difficulties performing routine household chores, climbing stairs, sleeping on his left side, remembering conversational content, and tying shoelaces due to grasping and twisting deficits with his hands. (*Id.* at pp. 4-5.) He estimated his maximum physical capacities of sitting for 30 to 60 minutes, standing or walking for 30 minutes, and lifting 10 to 15 pounds. (*Id.* at p. 5.)

Mr. Vega determined that applicant's prior occupations as a shuttle van driver, car porter, and car washer required fast-paced, medium-exertion work that exceeded his current physical work restrictions. (*Id.* at pp. 11, 14-15.) Mr. Vega opined that those restrictions left applicant with only a limited range of light or sedentary occupations, such as sewing-machine operator, but that such work requires frequent to constant use of the hands and arms and average manual and finger dexterity, which he found applicant lacked. (*Id.* at p. 16.) Mr. Vega further concluded that applicant was not a suitable candidate for vocational retraining into alternative sedentary employment because of his limited formal education and cognitive test results. (*Id.* at pp. 10, 15-16.) Mr. Vega attributed this conclusion to the combined effects of cognitive pace deficits, poor manual dexterity, and severe chronic pain requiring frequent positional changes, which he opined would interfere with applicant's ability to acquire new skills, meet productivity expectations, and sustain a competitive work schedule. (*Id.* at pp. 15-16.) Mr. Vega therefore concluded that applicant had no transferable skills and was not feasible for a return to his prior employment, other employment, or vocational retraining in the open labor market. (*Id.* at p. 16.)

Consequently, Mr. Vega concluded that applicant cannot maintain a competitive work pace, rendering him permanently and totally disabled from the open labor market. (*Id.* at pp. 3, 6, 16-17.)

In his December 17, 2024 supplemental report, Mr. Vega disagreed with Mr. Corso's analysis, explaining that the analysis increased applicant's post-injury specific vocational preparation levels, fingering aptitudes, and linguistic capabilities beyond the historical and tested baselines to identify alternative occupational matches. (App. Ex. 14, p. 2, fns.1-2.)

Mr. Da Silva conducted vocational testing of applicant via Zoom on August 20, 2024, and authored a report dated August 27, 2024, which recorded a ninth-grade education in Michoacán, Mexico. (Def. Ex. L, pp. 5-6.) On the Adult Basic Learning Examination, Level Two, administered in English, applicant demonstrated reading comprehension at an eighth-grade level in the 66th percentile, vocabulary at a seventh-grade level in the 63rd percentile, spelling at a fifth-grade level in the 38th percentile, and arithmetic computation at a fifth-grade level in the 21st percentile. The Spanish version of the same examination yielded reading comprehension at a 10th-grade level in the 73rd percentile and vocabulary at a 10th-grade level in the 71st percentile. (*Id.* at pp. 3, 6.) On the Raven Standard Progressive Matrices test, applicant scored in the "below average to average range," at the seventh percentile, correctly answering 27 of 60 problems. (*Id.* at pp. 2, 6.) On the Minnesota Clerical Test, applicant scored in the 10th percentile for both number and name comparisons. On the Bennett Mechanical Comprehension Test, he scored in the 13th percentile on the timed test. On the Career Ability and Placement Survey Manual Speed and Dexterity Test, he obtained a raw score of 176, corresponding to the 17th percentile. (*Id.* at pp. 4, 6.)

In his October 3, 2024 vocational report, Mr. Corso recorded that applicant completed the ninth grade in Mexico at age 14 and later attended Evans Adult School for one to two years of English as a Second Language (ESL) instruction. (Def. Ex. O, pp. 9-10.)

Mr. Corso opined applicant lacks the capacity to return to his prior medium exertion work as a Shuttle Van Driver, Car Porter and Cleaner II due to his physical restrictions. (*Id.* at pp. 16-17, 22.) Mr. Corso assessed applicant as capable of employability in the open labor market by determining a post-injury residual functional capacity for sedentary to light exertion work that requires lifting no more than 20 pounds. (*Id.* at pp. 16-17.) Mr. Corso performed a transferable skills analysis using the Dictionary of Occupational Titles to identify 439 occupational matches suitable for the physical restrictions of applicant. (*Id.* at pp. 23-24.) Mr. Corso identified open labor market positions applicant can perform, including Cashier II, Sales Clerk, and Counter Clerk, which do not require prior skills or training. Mr. Corso concluded applicant demonstrates feasibility for educational and vocational retraining to secure semiskilled positions such as Non-Emergency Dispatcher, Customer Service Clerk, and Order Clerk. (*Id.* at p. 40.) Mr. Corso clarified in his April 17, 2025 supplemental report that adjusting pre-existing language limits to average level factors out nonindustrial constraints, confirming that applicant has sufficient academic ability to benefit from remedial adult education and supportive vocational training. (Def.

Ex. P, pp. 2-3.) Mr. Corso concluded applicant remains fully capable of part-time or full-time employment in the competitive open labor market with reasonable accommodations such as alternative sitting and standing options. (Def. Ex. O, pp. 30-31, 47.)

Responding to Mr. Vega's criticism of the adjustment of post-injury aptitudes, Mr. Corso stated that vocational experts must exclude pre-existing, nonindustrial limitations when assessing injury-related disability, and explained that he normalized certain aptitude scores to average levels to account for applicant's limited English proficiency and ninth-grade education in Mexico. (Def. Ex. P, p. 2.) He emphasized that objective testing placed applicant in the high-average range for English vocabulary and reading comprehension and in the above-average range for Spanish reading comprehension. (Id. at pp. 3-4.) He also challenged Mr. Vega's reliance on the Minnesota Clerical Test, arguing that the test penalized applicant for his limited formal English education rather than measuring post-injury cognitive or learning deficits. (*Id.* at p. 4.) Mr. Corso identified several accessible occupational alternatives outside strictly clerical work, including positions in retail and hospitality that emphasize customer service and could utilize applicant's bilingual conversational ability. (*Id.* at pp. 3-4.) He further disputed Mr. Vega's conclusion that applicant lacked the capacity to acquire new skills, citing his professional experience transitioning unskilled workers into customer service positions through basic computer training. (*Id.* at p. 5.) Regarding conflicting observations of pain behavior during testing, Mr. Corso noted that Mr. Da Silva observed no pain expressions during the August 20, 2024, evaluation. (*Id.* at p. 6.) He further argued that fluctuations in subjective pain did not alter the objective medical restrictions identified by PQME Dr. Gendelman, which permitted light and sedentary work. (*Id.* at p. 7.) Finally, Mr. Corso criticized Mr. Vega's assignment of Level 5 to applicant's manual and finger dexterity aptitudes, asserting that Mr. Vega applied production and assembly norms to general occupational requirements and thereby treated applicant as unable to perform those functions. (*Id.* at pp. 7-8.) Mr. Corso concluded that these adjustments artificially eliminated otherwise viable occupational matches without support from the medical evidence. (*Id.* at p. 8.)

DISCUSSION

IV.

Permanent disability refers to the lasting, irreversible effects of an injury. It includes conditions that impair earning capacity, limit the normal use of a body part, or create a competitive

disadvantage in the labor market. Permanent disability payments compensate workers for both physical loss and the reduction, partial or total, of their future earning potential. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1320 [72 Cal.Comp.Cases 565].)

In *Department of Corrections and Rehabilitation v. Workers' Comp. Appeals Bd*. (*Fitzpatrick*) (2018) 27 Cal.App.5th 607 [83 Cal.Comp.Cases 1680], the court concluded that the issue of whether an injured employee is permanently and totally disabled must be determined through impairment ratings by application of the AMA Guides pursuant to section 4660. In addition, a finding under section 4662(b), "in accordance with the fact," does not provide a second independent path to permanent total disability separate from section 4660. (*Id.* at p. 622; *Bermejo v. Jorge Castro Farms* [2019 Cal. Wrk. Comp. P.D. LEXIS 93, *18-19].)[3]

However, an injured employee may challenge the scheduled permanent disability rating by proving a calculation error or an omission of medical complications, or that the injury prevents rehabilitation and causes a greater loss of future earning capacity than the PDRS reflects. (*Fitzpatrick*, *supra*, *27* Cal.App.5th at pp. 613-614 and 618-620; see *Ogilvie v. Workers' Comp. Appeals Bd.* (2011) 197 Cal.App.4th 1262, 1274 [76 Cal.Comp.Cases 624]; *Contra Costa County v. Workers' Comp. Appeals Bd.* (*Dahl*) (2015) 240 Cal.App.4th 746, 758 [80 Cal.Comp.Cases 1119]; *LeBoeuf v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 234, 245-246 [48 Cal.Comp.Cases 587] (*LeBoeuf*).)

With respect to vocational evidence, where an injured employee's work restrictions due to industrial factors cause the loss of their ability to compete for jobs on the open labor market, this would result in a total loss of earning capacity and permanent total disability. (*Contra Costa County v. Workers' Comp. Appeals Board* (*Dahl*) (2015) 240 Cal.App.4th 746, 757 [80 Cal.Comp.Cases 1119]; *LeBoeuf, supra*, 34 Cal.3d at pp. 245-246; *Soormi v. Foster Farms* [2023 Cal. Wrk. Comp. P.D. LEXIS 170, *11-12] citing *Wilson v. Kohls Dep't Store* [2021 Cal. Wrk. Comp. P.D. LEXIS 322, *20–23.].)

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[3] Unlike en banc decisions, panel decisions are not binding precedent on other Appeals Board panels and WCJs. (See *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236].) However, panel decisions are citable authority and we consider these decisions to the extent that we find their reasoning persuasive, particularly on issues of contemporaneous administrative construction of statutory language. (See *Guitron v. Santa Fe Extruders* (2011) 76 Cal.Comp.Cases 228, 242, fn. 7 (Appeals Board en banc); *Griffith v. Workers' Comp. Appeals Bd.* (1989) 209 Cal.App.3d 1260, 1264, fn. 2 [54 Cal.Comp.Cases 145].) Here, we refer to these panel decisions because they considered a similar issue.

In *LeBoeuf*, the Supreme Court applied a standard of labor market reality stating that, "A permanent disability rating should reflect as accurately as possible an injured employee's diminished ability to compete in the open labor market. The fact that a worker has been precluded from vocational retraining is a significant factor to be taken into account in evaluating his or her potential employability." (*LeBoeuf, supra* 34 Cal.3d at pp. 245-246.) The court concluded, "This is to ensure that the permanent disability rating upon which an award is based accurately reflects both the permanent medical and vocational disabilities." (*Id.* at p. 243.)

Accordingly, to rebut the PDRS and establish permanent total disability, an injured employee must prove the following:

1) They received a work restriction(s), which requires substantial medical evidence.
2) The work restriction(s) precludes them from rehabilitation into another career field, which requires vocational expert evidence.
3) The work restriction(s) precludes them from competing on the open labor market, which requires vocational expert evidence.
4) The cause of the work restriction(s) is 100% industrial, which requires substantial medical evidence.

(*Valdovinos v. Universal Site Services, Inc.* [2025 Cal. Wrk. Comp. P.D. LEXIS 76, *14]; *Fiore v. Los Angeles Community College District* [2024 Cal. Wrk. Comp. P.D. LEXIS 297, *16-17].)

The law requires the Appeals Board to base its decisions on substantial evidence. (Lab. Code, §§ 5903, 5952(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. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) To constitute substantial evidence, a medical or vocational opinion must state its conclusions in terms of reasonable probability, avoid speculation, rely on pertinent facts and an adequate examination and history, and explain the reasoning supporting its conclusions. (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 621 (Appeals Board en banc).) Medical and vocational reports do not constitute substantial evidence when they contain known errors or rely on facts that are no longer germane, inadequate medical histories or examinations, or incorrect legal theories. Likewise, a medical or vocational opinion cannot support the Appeals Board's findings if it rests on surmise, speculation, conjecture, or guesswork. (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93].)

Here, we agree with the WCJ that Mr. Vega's vocational reporting constitutes substantial evidence. He administered standardized psychometric and dexterity testing, including the

Purdue Pegboard, Bennett Hand-Tool Dexterity, and Minnesota Rate of Manipulation Tests, which yielded very low dexterity scores. He also observed hand tremors, a slow work pace, and difficulty remaining seated due to pain. He evaluated applicant's preexisting educational and linguistic baseline as fixed environmental parameters and assessed how PQME Dr. Gendelman's industrial physical restrictions intersected with applicant's functional capacities. Based on his assessment of applicant's performance in manual dexterity and psychomotor processing, Mr. Vega concluded that applicant's industrially related work restrictions prevented him from performing his past work and, when considered together with the identified deficits, prevented him from meeting the demands of alternative light or sedentary employment. Mr. Vega therefore opined that applicant could not compete in the open labor market or benefit from vocational rehabilitation.

Defendant contends that Mr. Vega rendered unauthorized medical opinions by relying on functional limitations, specifically hand tremors, sitting and standing tolerances, and pace deficits, not contained in PQME Dr. Gendelman's reporting. We disagree. Mr. Vega recorded real-time observations of applicant's physical pace, continuous tremors, and positional tolerance while administering standardized vocational testing. Observing an injured employee's presentation and functional tolerances during testing falls squarely within the scope of a vocational assessment. These observations complement, rather than overwrite, PQME Dr. Gendelman's medical restrictions.

Conversely, Mr. Corso's assessment lacked a reliable foundation and therefore did not constitute substantial evidence. Rather than evaluating applicant as he actually exists in the open labor market, Mr. Corso artificially elevated applicant's aptitude and language baselines to hypothetical average scores. Although nonindustrial factors themselves are not vocationally measurable, *LeBoeuf* requires a vocational evaluator to assess the impact of industrial restrictions against the injured employee's actual, preexisting capabilities. By discarding applicant's authentic educational and linguistic limitations in favor of an inflated aptitude profile, Mr. Corso evaluated a hypothetical worker rather than applicant's actual competitive employability. Therefore, his identification of accessible open labor market positions relies upon legally impermissible assumptions.

Ultimately, the evidentiary record establishes that Mr. Vega provided a methodologically reliable vocational analysis by applying the medical restrictions to applicant's actual, preexisting capabilities and assessing their effect on his competitive employability in the open labor market,

whereas Mr. Corso's assessment relied on an artificially elevated hypothetical aptitude profile and therefore did not constitute substantial evidence.

V.

Finally, defendant asserts that the evidentiary record requires further development because PQME Dr. Gendelman did not review the vocational expert reports. We find this argument unpersuasive and decline to reopen the evidentiary record, as the vocational reports would not materially assist in resolving the issues presented. Nor do we find a basis to reopen the record to reassess apportionment. PQME Dr. Gendelman found no apportionment to nonindustrial factors and defendant did not meet its burden of establishing otherwise. The law places on defendant the burden of proving apportionment. (*Pullman Kellogg v. Workers' Comp. Appeals Bd. (Normand)* (1980) 26 Cal.3d 450, 456 [45 Cal.Comp.Cases 170]; *Kopping v. Workers' Comp. Appeals Bd.* (2006) 142 Cal.App.4th 1099, 1115 [71 Cal.Comp.Cases 1229].) Thus, applicant does not bear the burden of disproving apportionment where defendant has not produced substantial medical evidence establishing it. (*Alcantar v. Martinez* [2025 Cal. Wrk. Comp. P.D. LEXIS 231, *9]; *Moraido v. County of San Diego* [2024 Cal. Wrk. Comp. P.D. LEXIS 375, *13, fn. 3]; *Arias v. Williams Roofing Co.* [2024 Cal. Wrk. Comp. P.D. LEXIS 29, *5]; *Matias v. Naturipe Berry Growers* [2024 Cal. Wrk. Comp. P.D. LEXIS 52, *4]; *Herrera v. Maple Leaf Foods* [2018 Cal. Wrk. Comp. P.D. LEXIS 430, *15].) We therefore decline to order further development of the record to cure an evidentiary deficiency on an issue for which defendant bears the burden of proof.

Accordingly, we deny the Petition for Reconsideration.

For the foregoing reasons,

IT IS ORDERED that defendant's Petition for Reconsideration of the Findings of Fact & Order issued on June 18, 2026 is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSÉ H. RAZO, COMMISSIONER

I CONCUR,

/s/ LISA A. SUSSMAN, DEPUTY COMMISSIONER

/s/ JOSEPH V. CAPURRO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

September 11, 2026

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

JOSE LUIS VALENCIA
PISEGNA & ZIMMERMAN, LLC
HANNA, BROPHY

DLP/md

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