WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

NERISSA WATSON, *Applicant*

vs.

COUNTY OF LOS ANGELES, permissibly self-insured, administered by SEDGWICK CLAIMS MANAGEMENT SERVICES, INC., *Defendants*

Adjudication Numbers: ADJ8545914; ADJ9694061
Marina Del Rey District Office

OPINION AND DECISION AFTER RECONSIDERATION

We previously granted reconsideration to allow us time to further study the factual and legal issues in this case. This is our Opinion and Decision After Reconsideration.

Defendant seeks reconsideration[1] of the Second Amended Findings and Award (F&A) issued on June 3, 2024. The workers' compensation administrative law judge (WCJ) found that applicant, while employed by defendant as a Detention Services Officer during the period of October 1, 2009 to January 1, 2012, sustained injury arising out of and in the course of her employment (AOE/COE) to her right wrist, right hand, left knee, heart, lungs, psyche, headaches, and gastrointestinal system, resulting in 100% permanent disability.

Defendant contends that the WCJ erred and acted in excess of her powers by failing to apply apportionment correctly pursuant to Labor Code sections 4663 and 4664.[2] Furthermore, defendant asserts it was denied its due process right to conduct discovery, specifically the right to cross-examine the Agreed Medical Evaluators (AME) on all issues, particularly regarding apportionment in accordance with *Benson v. Permanente Med. Group* (2007) 72 Cal.Comp.Cases 1620, 1622 (Appeals Board en banc) (*Benson*).

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[1] Defendant's petition for reconsideration included ADJ8545914 in its caption referencing an industrial injury during the period October 1, 2008 to October 1, 2009 to the right hand and fingers, left knee, heart, skin and immune system (in the form of a staph infection). However, the parties resolved that case by stipulations with request for award on July 13, 2015 and the WCJ's Second Amended F&A did not adjudicate any issues relating to that case. Consequently, in the absence of any decision defendant can claim to be aggrieved by, we will limit the scope of our review to ADJ9694061.

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

Defendant further claims that the vocational rehabilitation reports of Enrique Vega, M.A., do not constitute substantial vocational or medical evidence because they fail to comply with *Nunes v. State of California, Dept. of Motor Vehicles* (2023) 88 Cal.Comp.Cases 741 (Appeals Board en banc) (*Nunes I*) and do not establish a successful rebuttal of the Permanent Disability Rating Schedule (PDRS) pursuant to *Ogilvie v. Workers' Comp. Appeals Bd.* (2011) 197 Cal.App.4th 1262, 1277 [76 Cal.Comp.Cases 624].

Finally, defendant contends that the Appeals Board has a duty under these circumstances to develop the record further to achieve substantial justice.

We have received an Answer to the Petition for Reconsideration from applicant, and the WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending that we deny defendant's petition.

We have considered the allegations in the Petition and the Answer, as well as the contents of the WCJ's Report. Based on our review of the record, and for the reasons discussed below, as our Decision After Reconsideration we will rescind the WCJ's decision and substitute a new decision deferring issues related to permanent disability and attorney fees. We otherwise make no substantive changes to the decision.

BACKGROUND

I.

Applicant, while employed as a detention services officer with defendant during the period October 1, 2009 to January 1, 2011, sustained industrial injury AOE/COE to her right wrist, right hand, left knee, heart, lungs, psyche, headaches, and gastrointestinal system (ADJ9694061). (Minutes of Hearing and Summary of Evidence (MOH/SOE), 03/06/2019, 2:5-9.)

On January 25, 2010, the parties executed stipulations with request for award in ADJ2576517 (LBO 0375669) in which they stipulated that applicant, on December 25, 2005, sustained industrial injury AOE/COE to her left knee resulting in 24% permanent disability based on the opinion of AME Stephen Wertheimer, M.D., with an Award dated February 10, 2010.

On July 13, 2015, the parties executed stipulations with request for award for ADJ8545914 wherein applicant, during the period October 1, 2008 to October 1, 2009, sustained industrial injury to her right hand, right wrist, left knee, heart and lungs resulting in 49% permanent disability with

dismissal of the petition to reopen for ADJ2576517 (LBO 0375669), based on the opinions of AME Dr. Wertheimer and AME Mark Hyman, M.D., with an Award concurrently issued.

The parties concurrently executed stipulations with request for award in ADJ9694061 wherein applicant they stipulated that applicant sustained injury AOE/COE to the same parts of body during the period January 1, 2010 to January 1, 2011 resulting in 6% permanent disability based on the opinions of AME Dr. Wertheimer and AME Dr. Hyman, with an Award concurrently issued. On August 31, 2015, applicant filed a timely petition to reopen ADJ9694061, alleging she sustained new and further temporary and/or permanent disability and need for further medical treatment.

Thereafter the matter proceeded to trial, scheduled for March 6, 2019. At that time, the parties amended the date of injury to October 1, 2009 to January 1, 2011 and proceeded to trial on, among other issues, parts of body injured, permanent disability and apportionment. (MOH/SOE, 03/06/2019, 2:5-6, 2:22-24.)

The parties jointly submitted into evidence the AME reports of Howard Greils, M.D. (Court Exs. X1-X3), Mark Hyman, M.D. (Court Exs. Y1-Y6), and Stephen Wertheimer, M.D. (Court Exs. Z1-Z13.) Applicant submitted into evidence the vocational expert reports of Mr. Vega. (App. Exs. 2, 6.)

At trial, applicant testified in pertinent part as follows:

She stated that she had knee surgery in 2005 or 2006 for a torn meniscus, followed by two revision surgeries and cortisone injections. (MOH/SOE, 03/06/2019, 4:21-24.) She subsequently underwent three surgeries at the University of Southern California, including a debridement, and developed sepsis in 2011 that necessitated open-heart surgery. (MOH/SOE, 03/06/2019, 4:25 to 5:1.) During that operation her heart stopped, requiring a temporary pacemaker and a seven-day stay in the intensive care unit, followed by the implantation of a permanent pacemaker for the upper and lower heart. She later underwent additional knee surgery to inspect for infection, a knee replacement in 2011, and experienced a subsequent post-replacement infection. (MOH/SOE, 03/06/2019, 5:2-5.)

Regarding her current physical and gastrointestinal condition, during the 30 days prior to the hearing she suffered severe monthly migraines accompanied by vomiting, light sensitivity, and medication use, as well as persistent headaches and chest issues and a paralyzed hand due to nerve damage. (MOH/SOE, 03/06/2019, 5:6-9.) She described stomach problems including vomiting and inability to eat, which on one occasion caused a 30-pound weight loss. (MOH/SOE, 03/06/2019, 5:8-10.) Regarding her lower extremities, her left knee hurts constantly, requiring Norco and Motrin, her right knee aches, she walks with a limp, and her left foot and ankle swell. (MOH/SOE,

03/06/2019, 5:10-12.) She also stated that cold temperatures prevent her from moving due to bodily pain. (MOH/SOE, 03/06/2019, 5:13-14.)

She suffers from depression, frequent crying, and an inability to get out of bed or shower. (MOH/SOE, 03/06/2019, 5:12-14.) She experiences severe sleep disruption and nightmares linked to her extended intensive care unit stay. (MOH/SOE, 03/06/2019, 5:19-20.) She experiences weekly panic attacks during which her hands sweat, she shakes, and her elevated heart rate causes her pacemaker to shock her. (MOH/SOE, 03/06/2019, 5:15-16.) To manage these attacks, she takes Xanax, lies down, and completely isolates herself from other people. (MOH/SOE, 03/06/2019, 5:16.) She experienced a panic attack in the parking lot on the day of the hearing and another during her testimony. (MOH/SOE, 03/06/2019, 5:17-18.)

Her initial knee pain began in 2005 and worsened due to surgery and restraints. (MOH/SOE, 03/06/2019, 5:22-23.) She had three prior workers' compensation cases, noting that a left knee injury settled for 24% permanent disability, another case settled for 49% permanent disability, and the injury subject to the current proceeding settled for 6% permanent disability. (MOH/SOE, 03/06/2019, 5:23-25 to 6:1.) She acknowledged background personal stressors noted in medical reports, including a 2010 suicide attempt, a 2011 bankruptcy, loss of her home in 2013, and her husband's job loss in 2015, agreeing that these events and related treatment occurred prior to the August 2015 settlement. (MOH/SOE, 03/06/2019, 6:2-7.)

The matter was thereafter submitted for decision, and the WCJ issued several findings and orders to develop the medical record. On November 2, 2023, the WCJ issued an F&O ordering supplemental reporting from AME Dr. Wertheimer with a complete *Benson, supra,* analysis, and applicant's counsel sought removal. On January 23, 2024, we issued an Opinion and Order Granting Reconsideration and Decision after Reconsideration (Opinion) in which we concluded that:

> [T]he order to develop the record with respect to apportionment will result in irreparable harm to applicant. The Appeals Board does not have a duty to develop the record where a party who has the burden of proof recognizes the insufficiency of the record and does not take appropriate action. (*Lozano v. Workers' Comp. Appeals Bd.* (2002) 67 Cal.Comp.Cases 970 [2002 Cal. Wrk. Comp. LEXIS 1420] (writ den.).)

(Opinion, p. 7.)

Thereafter, the matter was returned to the trial calendar on February 29, 2024, at which time the case was submitted for decision. An initial F&A issued on May 16, 2024, which was thereafter twice amended by the WCJ.

On June 3, 2024, the WCJ issued her Second Amended F&A, awarding applicant 100% permanent disability. In her Opinion on Decision, she relied on the AMEs and Mr. Vega. (Opinion on Decision, p. 3.)

In her Report, the WCJ stated the following:

In the case at bar, Dr. Howard Greils addressed **Benson** as follows:

> "This examiner cannot with reasonable medical probability, parcel out the approximate percentages to which each distinctive industrial injury causally contributed to Ms. Watson's overall permanent disability on a psychiatric basis therefor, I will state that I am able to make an apportionment determination and that determination is as follows: Approximate percentage of disability caused by each of the relevant issues in this case cannot reasonably be determined … There is a synergistic effect between the two or more injuries which does not allow permanent disability from one to be separated from the permanent disability from the others (i.e. the overall disability is greater than simply the sum of the injuries, such that each part cannot be reasonably evaluated separately)." (Exhibit X1).

> All three AMEs opined that the injuries are "inexplicably intertwined". The AMEs are unable to apply **Benson** which justifies a joint award. (**Grumman Assistance Corporation v. WCAB (Dileva) (2015) 80 CCC 749**). Petitioner failed to cross-examine the AMEs or ask the WCJ to appoint a regular doctor.

(Report, p. 5.)

It is from this Second Amended F&A that defendant seeks reconsideration.

II.

Applicant was treated and evaluated extensively for her industrial injury claim, and the following relevant medical information was noted:

On April 12, 2007, AME Dr. Wertheimer evaluated applicant, who was six weeks post arthroscopic surgery on the left knee. (Court Ex. Z8, p. 6.) She presented with subjective complaints of constant pain in both knees, attributing the right knee pain to overcompensating for the injured left knee. (*Id.* at pp. 1-2.) She reported frequent giving way and swelling of the left knee, along with significant difficulties performing daily activities such as climbing stairs, kneeling, walking long distances, and getting down on the floor. (*Id.* at pp. 3-4.) During the physical examination, AME Dr. Wertheimer observed an antalgic gait on the left side and an inability to squat due to anterolateral discomfort of the left knee. (*Id.* at p. 5.) Range of motion (ROM) in the left knee was

restricted to 0° to 100°, accompanied by a loud clunk, a grinding sensation, positive patellar grinding signs, positive apprehension, and medial joint line tenderness. Right knee ROM was 0° to 140° without pain. Roentgenograms of the left knee revealed lateral joint space narrowing, a large osteophyte on the lateral femoral condyle, and at least four loose bodies, while the right knee showed a lateral bias of the patella. AME Dr. Wertheimer diagnosed a subluxing patella with multiple loose bodies in the left knee and a subluxing right patella. (*Id.* at p. 6.)

On March 12, 2008, following a review of the submitted medical file, AME Dr. Wertheimer issued a report reiterating that the condition of applicant had remained unstable during the prior evaluation and that she needed surgery for her subluxing patella. (Court Ex. Z7, p. 5.)

On May 6, 2008, AME Dr. Wertheimer reexamined applicant. On March 28, 2008, applicant sustained a subsequent incident at work when she slipped on debris on a staircase, twisting her low back and landing on her left side, exacerbating her left knee and lower back pain. (Court Ex. Z6, p. 2.) She reported that her constant left knee pain remained her worst complaint that worsened her occasional right knee pain and introduced new low back symptoms following the recent slip and fall. (*Id*. at pp. 3-4.) The examination demonstrated lumbar flexion of 69°, extension of 26°, and left lateral bending of 36° and right lateral bending of 38°, yielding 0% whole person impairment (WPI) for the lumbar spine. (AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), Table 15-9, p. 409.) (*Id.* at pp. 8-9.) Left knee ROM was 0° to 120° with pain. (*Id.* at p. 9.) Diagnostic imaging of the left knee showed a 0 mm joint interval upon weight bearing. (*Id.* at p. 10.) AME Dr. Wertheimer determined the March 28, 2008 injury aggravated the left knee and introduced back pain. (*Id.* at p. 11.) AME Dr. Wertheimer advised the use of an unloading brace and a cane to delay the need for a total knee replacement due to the young age of applicant. (*Id.* at pp. 12-13.)

On October 6, 2009, AME Dr. Wertheimer reexamined applicant, who reported significant improvement, a 40-pound weight loss, and mostly resolved low back pain. (Court Ex. Z5, pp. 2-3. 12.) In July 2009, she gave birth to a daughter. (*Id.* at p. 2.) In September 2009, she returned to full time regular duty as a detention service officer, performing her job duties without physical altercations. (*Id.* at pp. 2, 12.) AME Dr. Wertheimer noted a normal heel to toe gait and bilateral knee ROM of 0° to 125°. (*Id.* at p. 11.) He concluded applicant had reached maximum medical improvement. Relying on the 0 mm joint interval observed on full weight bearing imaging, he assigned 20% WPI impairment rating for the left knee traumatic arthritis. (AMA Guides, Table 17-31, p. 544.) AME Dr. Wertheimer precluded applicant from kneeling, crawling, and

running. (*Id.* at p. 15.) AME Dr. Wertheimer opined that the permanent disability was entirely industrial in nature, representing cumulative trauma induced traumatic arthritis. (*Id.* at p. 16.)

On January 8, 2013, he reexamined applicant five weeks postpartum after the birth of her son for complaints including left knee pain, intermittent right knee pain, occasional low back pain, and a notable loss of right hand and finger dexterity. (Joint Ex. Z4, pp. 1-2, 11.) On January 5, 2011, she ceased working due to the onset of severe septicemia. (*Id.* at pp. 2, 11, 13.) This medical emergency developed after multiple steroid injections introduced a Staphylococcal infection into the left knee. (*Id.* at pp. 3, 13.) The infection progressed to systemic septicemia and endocarditis, which required emergency open-heart surgery for a tricuspid valve replacement on February 6, 2011 and the insertion of a pacemaker on February 14, 2011. (*Id.* at pp. 3, 11, 13.) During the cardiac surgery, she suffered prolonged nerve compression on the operating table, resulting in right hand muscle paralysis and a right wrist ulnar nerve palsy. (*Id.* at pp. 11, 13.)

For the left knee total replacement, AME Dr. Wertheimer assessed 30 points for mild pain with walking and standing, 22 points for ROM, and 25 points for stability, resulting in a total of 77 points. This score yields a "fair" result, equating to 20% WPI for the left knee. (AMA Guides, Table 17-33, p. 547; Table 17-35, p. 549.) (*Id.* at p. 14).

For the right upper extremity ulnar nerve lesion at the elbow, he assigned a 60% severity factor to both the sensory and motor deficits (AMA Guides, Table 13-23, p. 346). He applied this severity factor to the applicable maximum values for the ulnar nerve and then combined the resulting sensory and motor components to calculate 25% upper extremity (UE) impairment (AMA Guides, Table 16-15, p. 492). He then converted the 25% UE impairment to 15% WPI (AMA Guides, Table 16-3, p. 439). (*Id.* at pp. 14-15.)

Using the combined values chart (CVC), the 20% WPI for the left knee and 15% WPI for complications from her open-heart surgery combine to produce 32% WPI orthopedically. (AMA Guides, p. 604.) (*Id.* at p. 15.)

On January 7, 2014, AME Dr. Wertheimer testified in a deposition regarding the medical cascade. He explained that the original left knee injuries caused a chronic inflammatory process, which necessitated the treatment that led to the severe infections. (Court Ex. Z12, p. 12:13-24.) In his deposition dated January 26, 2023, he further testified that the prolonged bedridden state caused muscle deterioration, scar tissue formation, and loss of ROM causing gait derangement and further affected the arthritic knee. (Court Ex. Z10, pp. 8:25 to 10:1-9.)

On March 8, 2014, a medical reexamination documented constant left knee soreness that varies in intensity, intermittent right knee pain, and constant low back pain radiating to the left buttock, leg, and foot. Applicant additionally reports a loss of right hand and finger dexterity, alongside an inability to open fully the right hand, with her worst complaints being the low back and left knee pain. (Court Ex. Z3, pp. 1-2.)

On September 23, 2014, AME Dr. Wertheimer provided further deposition testimony establishing two distinct periods of cumulative trauma. He identified the first period as commencing in September 2005 and ending in September 2009 when applicant returned to regular duty. He identified the second period as beginning in October 2009 and ending in January 2011 when applicant ceased working due to the septicemia. (Court Ex. Z13, pp. 37:22-25 to 38:1-8; 38:15-25 to 39:1-2.) He apportioned 90% of the permanent disability for the left knee and right wrist to the first period of continuous trauma, and the remaining 10% to the second period. (*Id.* at pp. 39:3-18 to 40:1-24; 52:8-19.)

On January 19, 2016, he evaluated applicant who presented with subjective complaints of a loss of right hand and finger dexterity, an inability to open her right hand completely, and intermittent low back pain radiating into the left buttock and down the posterior left lower extremity. (Court Ex. Z1, p.1.) She additionally described frequent right knee aching pain and constant left knee pain that extended up her posterior left leg to her back. (*Id.* at p. 2.) She reported experiencing significant depression, spending entire weekends in bed, and crying during the evaluation. (*Id.* at pp. 3, 6, 12, 14.) AME Dr. Wertheimer examination of the upper extremities revealed the right hand postured in a clenched position, though applicant could relax her fingers upon command, and wrist dorsiflexion measured 80° bilaterally against an estimated normal of 60°. (*Id.* at p. 8-9.) Jamar dynamometer grip strength testing yielded 27, 24, and 22 kg of force on the right major hand, and 27, 29, and 29 kg on the left. (*Id.* at p. 11.) Objective evaluation of the lumbar spine demonstrated no scoliosis, kyphosis, or tenderness, with a negative straight leg raise at 90° bilaterally. (*Id.* at pp. 9-10.) Evaluation of the lower extremities showed a 0° to 120° ROM in the right knee and a 0° to 95° range in the left knee, alongside left medial collateral ligament laxity, positive right patellar grinding, and anserine tenderness on the right. (*Id.* at pp. 10-11.) Diagnostic imaging revealed a small loose body at the right radiocarpal joint, loose bodies and a total joint replacement with bone cement in the left knee, and a lateral bias of the right patella. AME Dr. Wertheimer subsequently diagnosed applicant with a status post left knee arthroscopy with a subluxing patella, multiple left knee loose bodies, a right knee subluxating patella, post staph septicemia, a status post cardiac valve surgery for

endocarditis, a right ulnar nerve palsy, a septic left knee followed by a total joint replacement, and depression. (*Id.* at p. 12.) AME Dr. Wertheimer measured lumbar flexion at 65°, representing 108% of normal spinal flexion. Utilizing a sacral flexion angle of 45° or above yielded 0% WPI. He measured lumbar extension at 22° to find 2% WPI. (AMA Guides, Table 15-8, p. 407.) Left lateral bending measured 26°, representing 104% of normal and right lateral bending measured 28°, representing 112% of normal, yielding 0% WPI for each. (AMA Guides, Table 15-9, p. 409.) He concluded that applicant sustained 2% WPI total lumbar region ROM. (*Id.* at p. 10.) Furthermore, he referenced his prior January 8, 2013 evaluation, reiterating 20% WPI for a fair result from the left total knee replacement and 15% WPI caused by septicemia, producing a combined 32% WPI orthopedic impairment. (Joint Ex. Z4, p. 14; Court Ex. Z1, p. 14.)

He noted the left knee Staph infection and ensuing septicemia possibly resulted from multiple steroid injections administered to the left knee, which ultimately necessitated open-heart surgery for endocarditis. He reiterated his October 6, 2009 conclusion that the permanent disability was 100% industrial and stated that any worsening constituted a repetitive trauma injury. (*Id.* at p. 13.)

In his reevaluation of applicant on September 11, 2019, she expressed subjective complaints characterized by worsening right hand weakness, limited mobility, and an overall loss of use of her right hand and fingers. (Court Ex. Z9, pp. 1, 3.) She described achiness, intermittent numbness, and an inability to open her right hand independently, noting she relies on her opposite hand to pry her fingers open. Additional subjective complaints included back pain, bilateral knee pain, neck pain, bilateral trapezius and shoulder pain, and chest pain. (*Id.* at p. 3.)

AME Dr. Wertheimer diagnosed applicant with a peripheral nerve lesion of the right upper extremity caused by a surgical complication. (*Ibid.*) AME Dr. Wertheimer traced the impairment back to January 2011 when a staphylococcal infection involving Staph aureus in the left knee developed into severe septicemia, meningitis, and endocarditis. Treatment for these complications required open-heart surgery to replace a valve, after which applicant awoke with right hand muscle paralysis. AME Dr. Wertheimer identified an ulnar nerve compression injury sustained during the open-heart surgery. (*Id.* at p. 12.) He apportioned the entire disability to the industrial injury, finding that the impairment resulted solely from medical treatment of the original industrial left knee injury. (*Id.* at p. 14.)

In calculating permanent disability, he quantified total cervical region ROM impairment at 9% WPI. (flexion at 45° (2% WPI), extension at 42° (2% WPI), left lateral bending at 28°, (2% WPI) right lateral bending at 33° (1% WPI), left rotation at 67° (1% WPI), and right rotation at 64°

(1% WPI)) (AMA Guides, Table 15-12, p. 418; 15-13, p. 420, 15-14, p. 421.) (*Id.* at pp. 7-8.) Evaluation of the upper extremities yielded 6% UE impairment for the left shoulder and 6% UE impairment for the right shoulder (180° of bilateral flexion, 30° of bilateral extension, 90° of bilateral external rotation, 30° of bilateral internal rotation, 180° of bilateral abduction, and 20° of bilateral adduction) (AMA Guides, Figure 16-40, p. 476; Figure 16-43, p. 477; Figure 16-46, p. 479.) (*Id.* at pp. 8-10.) For the specific right upper extremity ulnar nerve injury, he evaluated sensory and motor loss. (AMA Guides, Table 16-10, p. 482; Table 16-11, p. 484.) By combining the motor and sensory deficits, he calculated 50% UE impairment. (AMA Guides, Table 16-15, p. 492.) He then converted this value into 30% WPI for the right upper extremity. (AMA Guides, Table 16-3, p. 439.) Finally, AME Dr. Wertheimer reduced this 30% WPI by 25% WPI to account for residual functionality, noting applicant retained her ability to drive and manipulate a steering wheel. The calculation produced a final rating of 23.5% WPI for the right ulnar nerve injury, and AME Dr. Wertheimer recommended adding the rating to her overall impairment from the knee trauma.[3] (*Id.* at p. 14.)

On January 26, 2023, he provided deposition testimony addressing the complexities of apportionment. He confirmed he had previously attempted to apportion the disability by assigning one-third to prior specific injuries and two-thirds to cumulative trauma in his August 22, 2022 report. (Court Ex. Z10, p. 6:4-7; Court Ex. Z11, pp. 2-3.) However, he testified that the specific dates of injury and the cumulative trauma periods overlap and intertwine rendering apportionment inherently speculative. (Court Ex. Z10, p. 10:2-9.) He stated that apportioning the disability among the three dates of injury in accordance with *Benson* to a reasonable degree of medical probability would merely be a gross estimate. (*Id.* at p. 10:20-25 to 11:1-16.) He concluded that the original injuries leading to the infection are responsible for the overall condition and that determining an exact apportionment percentage remains difficult and highly speculative. (*Id.* at pp. 11:19-25 to 12:1-10, 13:9-18.)

On September 22, 2014, AME Dr. Hyman evaluated applicant in the field of internal medicine. She subjectively complained of experiencing chest pain, palpitations, and ankle swelling

[3] We note several fundamental methodological and mathematical defects in this impairment calculation that preclude its standing as substantial medical evidence. The AMA Guides require an evaluator to establish the clinical severity grade of sensory and motor deficits using the appropriate upper extremity grading matrices before multiplying by the maximum peripheral nerve impairment values. (AMA Guides, Section 16.5b, pp. 481-482; Table 16-10a, p. 482; Table 16-11a, p. 484.) By abandoning this objective grading protocol in favor of an absolute maximum impairment coupled with a subjective, anecdotal discount, AME Dr. Wertheimer deviated from standard rating methodology without articulating a valid analysis pursuant to *Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd*. (*Almaraz/Guzman III*) (2010) 187 Cal.App.4th 808, 822 [75 Cal.Comp.Cases 837] grounded within the four corners of the AMA Guides. Furthermore, a 25% reduction of 30% WPI mathematically yields 22.5%, rather than the 23.5% concluded in the report.

every other day, describing the chest pain as a central sharp sensation lasting from 2 to 30 seconds. (Court Ex. Y3, p. 3.) She additionally reported experiencing weight change, muscle pain, joint pain, joint swelling, back pain, constipation, poor memory, anxiety, and poor sleep. (*Id*. at p. 4.)

During the objective physical examination, AME Dr. Hyman observed that applicant was obese with a body mass index of 31 and presented with a well-healed midline scar alongside a longitudinal left knee scar. Auscultation of her cardiovascular system revealed a mechanical S1 heart sound heard best at the second right intercostal space. (*Id.* at p. 5.) Diagnostic chest x-rays demonstrated a status post sternotomy with a mechanical valve ring at the tricuspid position and a well-healed subcutaneous device. (*Id.* at p. 6.) An electrocardiogram showed a sinus rhythm with right bundle branch block formation, while an echocardiogram by Ram Dandillaya, M.D., dated September 22, 2014 revealed a bioprosthetic tricuspid valve, a pacing catheter in the right-sided chambers, mild tricuspid regurgitation, and an estimated ejection fraction of 60%. (*Id.* at pp. 7, 18.) AME Dr. Hyman noted that pulmonary function testing demonstrated no significant residual limitation, though he assessed minor residual impairment due to altered lung circulation. (*Id.* at p. 8.)

He opined that applicant sustained a documented history of industrially related orthopedic injuries to her left knee requiring repeated surgical interventions. He established that these repeated surgical interventions led to a Staph aureus septicemia infection when the bacteria, typically located on the skin, was introduced into her bloodstream. The bacteria caused a change to the interior of her heart and damaged the tricuspid valve. Consequently, AME Dr. Hyman concluded that all ongoing documented cardiopulmonary difficulties, including the emergency interventions at Lakewood Hospital and USC Hospital, represent industrially related consequences of her surgical orthopedic intervention. (*Ibid.*)

He assigned 9% WPI for the status post tricuspid valve replacement. (AMA Guides, Table 3-5, Class 1, p. 30.) He assigned 9% WPI for the status-post pacemaker placement with residual right bundle branch block formation. (AMA Guides, Table 3-11, Class 1, p. 56.) He assigned 5% WPI for pulmonary embolization. (AMA Guides, Table 4-3, Class 1, p. 70.) AME Dr. Hyman noted that the impairment ratings for the pacemaker and valve replacement consider each other to arrive at a fair impairment rating, and he rated the pulmonary embolus by analogy to aortic disease because it best approximated her altered circulatory condition. He determined applicant's cardiopulmonary complications directly resulted from her orthopedic conditions, formally concluding there was no basis for apportionment to non-industrial factors. (*Id.* at p. 9.)

In AME Dr. Hyman's reevaluation dated January 18, 2016, he recorded applicant's subjective complaints as including depression, a decrease in appetite, and weight loss down to 160 pounds. She reported developing neck headaches with a dull sensation in 2014, accompanied by dizzy spells, watery or itchy eyes, and ringing of the ears. She describes experiencing chest pain, palpitations, and ankle swelling, specifically noting sharp left-sided chest pains lasting two seconds that occur twice a week. She also complained of ongoing joint pain, joint swelling, back pain, and heartburn occurring twice daily for many years, which she treats with papaya seeds. (Court Ex. Y1, p. 2.) Furthermore, she reports poor memory, anxiety, and panic attacks resulting in poor sleep. (*Id.* at p. 3.)

AME Dr. Hyman measured applicant's height at 5 feet 3.5 inches, weight at 162 pounds, and blood pressure at 130/80. (*Ibid*.) She had a well-healed sternotomy scar and a left upper chest wall scar with a subcutaneous pacemaker. (*Id.* at p. 4.) An electrocardiogram showed a sinus rhythm with a right bundle branch block. (*Id.* at p. 5.) A capsule endoscopy performed the same day revealed mild esophagitis and a questionable hiatal hernia. (*Id.* at pp. 5, 17.) An exercise treadmill test concluded after 4.5 minutes due to fatigue, reaching 85% of her maximum predicted heart rate, indicating a low probability of coronary artery disease. (*Id.* at pp. 5-6.) A urinalysis indicated a urinary tract infection. (*Id.* at p. 4.)

He concluded that applicant's endocarditis, tricuspid valve replacement, pacemaker placement, right bundle branch block formation, and septic emboli to the lungs are industrially related. (*Id.* at p. 6.) He determined that her chest pain complaints result from the sternotomy procedure and do not present a ratable impairment. AME Dr. Hyman stated that applicant's stress tension-type headaches with dizziness stem from her psychological difficulties ultimately deemed industrial by AME Dr. Greils. Regarding the gastroesophageal reflux disease, AME Dr. Hyman concludes it was partially industrial due to the pain of applicant's injuries, the stress of her injuries, and her psychological condition. (*Id.* at p. 7.)

He assessed 2% WPI for stress tension-type headaches (AMA Guides, Table 18-1, p. 571) and 9% WPI for gastroesophageal reflux disease. (AMA Guides, Table 6-3, Class 1, p. 121.) (*Id.* at p. 8.)

In his apportionment analysis, Dr. Hyman concluded in his March 16, 2023 supplemental report that his apportionment for the internal medicine conditions parallels the exact percentages established by AME Dr. Wertheimer and AME Dr. Greils across the respective claim periods. (Court Ex. Y5, p. 2.)

In his report dated September 7, 2016, AME Dr. Greils, after evaluating applicant in the field of psychiatry, attributed the onset of her physical and emotional conditions predominantly to her occupational duties. (Court Ex. X2, p. 127.) She reported that her job required repetitive physical motions and the physical restraint of minors, which caused her to develop severe bilateral knee pain beginning in approximately 2005. (*Id.* at p. 7.) She stated that diagnostic imaging revealed a torn anterior cruciate ligament and meniscus in her left knee, leading to multiple unsuccessful surgical repairs. (*Id.* at pp. 8-9.) She reported that she continued working despite chronic pain and began experiencing severe sleep disturbances, anxiety, and depression by 2006, prompting her to file an initial workers' compensation claim. (Court Ex. X2, p. 8.)

Beginning in early 2011, applicant's health suffered a significant deterioration when she lost consciousness and required emergency hospitalization for a severe staph infection, meningitis, and jaundice. (*Id.* at pp. 10-11.) Physicians diagnosed her with an exploded tricuspid valve, necessitating immediate open-heart surgery for a valve replacement, along with the surgical cleaning of her left knee to remove the staph infection. (*Id.* at pp. 11, 78.) Following the heart surgery, she required the implantation of a pacemaker and experienced right arm paralysis attributed to surgical nerve damage. (*Id.* at pp. 6, 11-12, 18, 78.) She stated that her extended stay in the intensive care unit traumatized her, resulting in panic attacks, flashbacks, and a brief, unsuccessful suicide attempt via pill overdose. (*Id.* at pp. 12, 14, 72, 80, 110.) She underwent a left knee replacement in 2011 and eventually returned to work on limited duty in April 2012, though she reports enduring constant severe physical pain, ongoing panic attacks, and crying spells in the workplace. (*Id.* at pp. 13-14, 80-81.) She noted that her supervisors frequently ignored her medical work restrictions, exacerbating her physical pain and psychological distress. (*Id.* at p. 17, 83, 88, 95.)

She described her current life situation as highly restricted, noting that she suffers from severe insomnia, averaging only three hours of sleep per night due to physical pain and daily nightmares regarding twisted memories. (*Id.* at pp. 20, 103.) She reports isolating herself from social interactions, completely losing her sex drive, and experiencing severe anxiety in crowded environments, such as a recent trip to an amusement park that triggered a severe panic attack. (*Id.* at pp. 21-22, 97, 106.) She reported ongoing marital stress after her husband lost his job in December 2015 and engaged in infidelity in early 2016. (*Id.* at pp. 16, 83, 87, 94.) She states that she sought medical retirement in 2015 based on evaluations from other AMEs who concluded she could no longer safely perform her job duties. (*Id.* at p. 17, 84, 95.)

During her psychological testing, she was cooperative but a poor historian. (*Id.* at p. 35.) During the testing, she would rub her back and shift positions in her chair. (*Id.* at p. 34.) AME Dr. Greils assessed her mood as depressed and anxious, rating her depression at a 3 out of 5 scale, noting intermittent sobbing alongside an abnormal level of emotional reactivity. (*Id.* at p. 35.) Her objective psychometric testing results indicated cognitive functioning within the low average to high average range, with applicant scoring in the 75th percentile on vocabulary and the 16th percentile on digit span and arithmetic subtests. (*Id.* at pp. 28-29.)

AME Dr. Greils found the Taylor-Johnson Temperament Analysis of questionable validity because of a negative test-taking bias and deemed the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) results invalid because of the large number of unusual responses. (*Id.* at p. 32.) The Epworth Sleepiness Scale yielded a score of 12, indicating excessive daytime sleepiness. (*Id.* at p. 34.)

AME Dr. Greils diagnosed under Axis One as Depressive Disorder Not Otherwise Specified with anxious features, Posttraumatic Stress Disorder of Delayed Onset, Sleep Disorder due to Pain and nightmares, and Female Hypoactive Sexual Desire Disorder Due to Pain with a Global Assessment of Functioning (GAF) score of 53 (23% WPI) (*Id.* at p. 71.) This correlates to moderate symptoms or moderate difficulty in social or occupational functioning. He also provided a historical timeline of her functioning, estimating a pre-morbid GAF score of 90 and a subsequent decline to 30 following a suicide attempt. (*Id.* at p. 72.) He identified contributing psychosocial stressors on Axis Four, which included stress secondary to orthopedic injury, internal medicine injury, her husband's unemployment, financial debt, and the death of a co-worker. (*Id.* at p. 71.)

In his reexamination report dated June 1, 2017, he recorded applicant's subjective physical complaints, which included constant pain in the low back and bilateral knees, chest pain, and partial paralysis in the right hand. She estimated her physical condition deteriorated by 20% since her original injury. AME Dr. Greils noted she experiences anxiety, sadness, poor sleep, anger, and specific triggers. (Court Ex. X1, p. 6.) She described suffering from anxiety attacks, breathing difficulties, sweating, and daily chest discomfort that typically occurs at night. She confirmed her emotional condition worsened but does not quantify the deterioration with a specific percentage. (*Id.* at p. 7.)

She medically retired from her job on December 7, 2016. She did not receive psychiatric treatment until March 2017, when she attended a single session with Perry Maloff, M.D., which she found unhelpful and detrimental to her mental state. She reports the workers compensation system

denied physical treatment, causing her to feel stagnant and tired of the process. (*Ibid.*) She currently manages her symptoms independently through prayer and yoga, and she expresses a strong desire to settle and close her case. (*Id.* at pp. 8, 13, 39-40, 42, 45.) She takes Xanax up to three times daily, Motrin, Aspirin, a water pill, and Norco. (*Id.* at p. 9.)

She requires her husband's physical assistance with personal hygiene. She prepares limited meals and receives household assistance from her mother-in-law, avoiding yard work entirely due to pain. (*Id.* at p. 10.) She reported poor sleep quality, averaging four hours per night, and identified anxiety as the primary disturbance, followed by physical pain. (*Id.* at pp. 11-12, 50.) She experienced nightmares about twice a week, occasional flashbacks, and avoids hospitals, crowds, and violent television. (*Id.* at p. 12-13, 45, 50.)

The Bender Visual Motor Gestalt Test and Memory for Designs Test revealed no evidence of organic errors. (*Id.* at p. 20.) The Babcock Story Recall Test demonstrated low-average initial recall and above-average secondary recall. (*Id.* at pp. 20-21.) The Wechsler Adult Intelligence Scale, Fourth Edition subtests indicated average short-term memory and general knowledge, with low-average arithmetic performance. The MMPI-2 noted a significantly elevated F scale score of 72, which suggests applicant may slightly overstate her symptomatology. (*Id.* at p. 21.) Clinical scale elevations occurred in hypochondriasis, depression, hysteria, psychopathic deviate, paranoia, psychasthenia, schizophrenia, and social introversion. (*Id.* at p. 22.) He categorizes the MMPI-2 findings as a 213/231 code profile, stating this pattern is consistent with individuals experiencing emotional suffering who need to call attention to their pain, often presenting with somatic complaints and potential secondary gain. (*Id.* at p. 25.)

Applicant reported subjective feelings of depression, equating to a three on a zero to five scale, alongside sadness, anger, and anxiety. (*Id.* at pp. 27, 41.) She experiences daily anxiety attacks and difficulty breathing, typically at night, and reports sweating and chest discomfort. (*Id.* at p. 41.) She struggles with sleep, obtaining an average of four hours per night, and awakens two to three times nightly due to pain. (*Id.* at pp. 11, 50.) She details nightmares occurring twice a week and occasional flashbacks. (*Id.* at pp. 12, 45, 50.) She takes Xanax at least once daily to manage anxiety and utilizes prayer and yoga for coping. (*Id.* at pp. 8, 40, 45.)

She scored 10 on the Epworth Sleepiness Scale indicating excessive daytime sleepiness. (*Id.* at p. 26.) She was cooperative and attentive but noted she was a poor historian with an affect ranging from blunted to hypervigilant to tearful. (*Id.* at p. 27.) She demonstrated pain-related behaviors, including frequent shifting, rubbing her back, and standing. (*Id.* at p. 26.) AME Dr. Greils

found applicant's memory slightly impaired, noting difficulty recalling specific dates and details, and observed that pain and anxiety affected her concentration over prolonged periods. She showed impairment in performing serial sevens but completed serial fives without errors. (*Id.* at p. 28.) Psychometric testing provided a pattern of elevations on scales one, two, three, and seven, supporting diagnoses related to somatic complaints, anxiety, and depression. (*Id.* at pp. 22, 42, 46.)

AME Dr. Greils diagnosed applicant with Depressive Disorder Not Otherwise Specified with anxious features, Posttraumatic Stress Disorder with delayed onset, Sleep Disorder due to pain, and Female Hypoactive Sexual Desire Disorder due to pain with a GAF score of 52 (27% WPI). (AMA Guides, Table 14-1, p. 363; 14-2, p. 367.) (*Id.* at pp. 36-37, 53, 55, 59, 68.) In addition, work function impairments comprise moderate across work pace, complex tasks, interpersonal relations, influencing others, independent decision-making, and carrying out responsibility, with slight impairment in following instructions and very slight impairment in simple tasks. (*Id.* at pp. 71–72.)

AME Dr. Greils determined the psychiatric injury predominantly resulted from the pain, limitations, and sequelae caused by her orthopedic condition. Because AME Dr. Wertheimer found the orthopedic condition to be industrial in causation, AME Dr. Greils concluded the psychiatric injury is also industrial in causation and apportioned it entirely to the stress secondary to the orthopedic pain and limitations and her accompanying complications. (*Id.* at pp. 33, 61.)

In his vocational report dated September 17, 2018, Mr. Vega, after evaluating applicant, took a history that she last worked in December 2016 and attempted a brief return to work as a general office clerk in March and April 2017, which she could not sustain due to panic attacks and an inability to get out of bed. (App. Ex. 2, pp. 3, 5.) Her employment history includes work as a Probation-and-Parole Officer and Teacher Aide II, both of which required light strength. (*Id.* at p. 4.) Mr. Vega notes that applicant cannot return to her previous physical occupations and she possesses no transferable skills for lighter occupations. (*Id.* at p. 12.)

Vocational testing administered on June 13, 2018, demonstrated average non-verbal intellectual functioning and academic achievement but revealed significant physical and cognitive limitations. (*Id.* at pp. 5-7.) Applicant scored in the very low to below-average ranges on the Purdue Pegboard Test, demonstrating poor finger dexterity while actively holding her right hand with her left hand due to nerve damage. (*Id.* at p. 6.) She discontinued the Minnesota Rate of Manipulation Tests due to right hand pain and worked at a slow pace. Furthermore, she scored in the very low range on the Minnesota Clerical Test and the Bennett Mechanical Comprehension Test. (*Id.* at p. 8.) She could not complete the Wide Range Achievement math computation subtest, the

Gates-MacGinitie reading comprehension section, or the Bennett Mechanical Comprehension Test within the allotted times, which Mr. Vega attributes to problems with concentration, persistence, and pace. (*Id.* at pp. 7-9.)

Mr. Vega opined that, considering the AMEs opinions and his evaluation, applicant is permanently and totally disabled, non-feasible for vocational rehabilitation, and unable to perform even basic job duties. (*Id.* at p. 2.) Her post-injury access to the open labor market and work life expectancy have fallen to zero. (*Id.* at pp. 13-14.) Mr. Vega emphasizes that while there is medical apportionment to earlier continuous trauma periods, applicant returned to work after 2009, meaning her total inability to compete in the open labor market stems entirely from her most recent industrial orthopedic impairments and the ensuing psychiatric and internal medicine complications. (*Id.* at p. 18.)

In his supplemental report dated August 21, 2020, Mr. Vega conducted new vocational testing on July 1, 2020, at the request of applicant's attorney to eliminate any potential distraction caused by the presence of applicant's son during the initial evaluation. (App. Ex. 6, pp. 1, 7.) During the evaluation, Mr. Vega observed that applicant provided her best effort but worked at a slow pace, alternated between sitting and standing, and frequently stretched or massaged her right hand. She appeared visibly tired and in pain by the end of the session, remarking that her entire body hurt. (*Id.* at p. 5.)

With respect to her vocational tests, on the Purdue Pegboard Test, she scored in the very low range for the right hand and both hands subtests, experiencing difficulty opening her right hand due to reported nerve damage and utilizing her left hand to assist the right. She discontinued the assembly subtest due to hand problems, indicating she would not be competitive for positions requiring strong finger dexterity. (*Id.* at p. 2.) She also attempted the Bennett Hand-Tool Dexterity Test and the Minnesota Rate of Manipulation Tests but discontinued both early due to severe right hand pain, demonstrating limited potential for occupations requiring manual dexterity. (*Id.* at pp. 3-4). Additionally, her right arm visibly shook during the Minnesota Clerical Test, where she scored in the very low range, indicating limited aptitude for clerical work. (*Id.* at p. 4.)

With respect to her cognitive and academic testing, the Beta Four assessment placed her non-verbal intellectual functioning in the low average range, a decrease from her prior score that Mr. Vega attributes to pain and a test version change. (*Id.* at pp. 2-3, 6.) While the Wide Range Achievement Tests showed average functioning in word reading, sentence comprehension, and math computation, applicant scored below average in spelling, experiencing writing difficulties and

massaging her right wrist during the subtest. (*Id.* at p. 3.) She failed to complete the Gates-MacGinitie Reading comprehension section and the Bennett Mechanical Comprehension Test within the allotted times, which Mr. Vega attributes to ongoing problems with concentration, persistence, and pace stemming from deterioration of her medical condition. (*Id.* at pp. 4-6.)

Mr. Vega concluded that applicant's scores remain largely consistent with the previous findings, confirming persistent deficits in manual dexterity, finger dexterity, and clerical aptitude. (*Id.* at p. 6.) He noted that her performance deteriorated on several tests in 2020 primarily due to pain. Relying on these consistent testing results and her significant physical impairments, Mr. Vega affirmed his previously expressed opinion that applicant cannot benefit from vocational rehabilitation services and possesses no access to employment in the open labor market. (*Id.* at p. 7.)

III.

As stated above, in our prior Opinion and Order Granting Petition for Reconsideration and Decision After Reconsideration, dated January 24, 2024, we rejected defendant's contention that the WCJ had improperly circumvented the statutory apportionment requirements imposed by section 4663 and *Benson*. We explained that, because defendant bore the burden of proving apportionment, its failure to carry that burden warranted an unapportioned award of permanent disability, and we further held that we had no duty to require development the record to assist defendant in satisfying that evidentiary burden. Nevertheless, in our subsequent Opinion and Order Granting Petition for Reconsideration, dated August 9, 2024, we found good cause to grant reconsideration and defer a final decision. This deferral allowed for further review of the AME reporting and the potential applicability of apportionment pursuant to section 4664(c), taking into consideration the interrelationship between the previously resolved stipulations for the October 1, 2008 to October 1, 2009 injury and the currently litigated reopened October 1, 2009 to January 1, 2011 injury. We now issue our decision in accordance with that review.

DISCUSSION

IV.

The Appeals Board has the *discretionary* authority to develop the record when the record does not contain substantial evidence or when appropriate to provide due process or fully adjudicate the issues. (Lab. Code, §§ 5701, 5906; *Tyler v. Workers' Comp. Appeals Bd.* (1997) 56 Cal.App.4th 389, 394 [62 Cal.Comp.Cases 924] ["principle of allowing full development of the evidentiary record

to enable a complete adjudication of the issues is consistent with due process in connection with workers' compensation claims."]; see *McClune v. Workers' Comp. Appeals Bd.* (1998) 62 Cal.App.4th 1117, 1121 [63 Cal.Comp.Cases 261]; *McDuffie v. Los Angeles County Metropolitan Transit Authority* (2001) 67 Cal.Comp.Cases 138, 142 (Appeals Board en banc).

Section 4664(c) states:

> (c) (1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:
>
> (A) Hearing.
>
> (B) Vision.
>
> (C) Mental and behavioral disorders.
>
> (D) The spine.
>
> (E) The upper extremities, including the shoulders.
>
> (F) The lower extremities, including the hip joints.
>
> (G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

In prior panel decisions, the Appeals Board has often taken a commonsense approach to assignment of disability to a body system. (See e.g., *Jordan v. California Dep't of Corrections*, [2018 Cal. Wrk. Comp. P.D. LEXIS 243, *5][4] [Wherein the panel, using the chapters of the AMA Guides, assigned cognitive impairment as a "mental and behavioral" disability under section 4664(c)(1)(C), and not disability to the "head" under section 4664(c)(1)(G).].) However, when the issue of assignment of a disability to a body system exists and is in dispute, such issue is of a medical nature, and the determination requires substantial medical evidence.

To constitute substantial evidence ". . . a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on

[4] 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.

an adequate examination and history, and it must set forth reasoning in support of its conclusions." (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 621 (Appeals Board en banc).)

"[T]he medical cause of an ailment is usually a scientific question, requiring a judgment based upon scientific knowledge and inaccessible to the unguided rudimentary capacities of lay arbiters." (*Peter Kiewit Sons v. I.A.C.* (*McLaughlin*) (1965) 234 Cal.App.2d 831, 839 [30 Cal.Comp.Cases 188].) "In a field which forces the experts into hypothesis, unaided lay judgment amounts to nothing more than speculation." (*Id.* at p. 840.)

The requirement for expert medical evidence exists throughout workers compensation proceedings, including determination of temporary disability, permanent disability, apportionment, and causation of injury to name a few. (See also *Escobedo*, *supra*, 70 Cal.Comp.Cases at p. 621 [wherein the Appeals Board required that apportionment under section 4663 be established by substantial medical evidence].)[5]

In many cases, it may be apparent, even to the layperson, what disability affects which body system. In such cases, the parties may stipulate to body systems under section 4664(c). However, as stated, where the parties dispute the body system, such a dispute requires medical evidence, especially where there are issues outside the knowledge of a layperson required to decide the issue.

The requirements for proving application of section 4664(c) are essentially no different than apportionment under 4664(b):

> First, the employer must prove the existence of the prior permanent disability award. Then, having established by this proof that the permanent disability on which that award was based still exists, the employer must prove the extent of the overlap, if any, between the prior disability and the current disability. Under these circumstances, the employer is entitled to avoid liability for the claimant's current permanent disability only to the extent the employer carries its burden of proving that some or all of that disability overlaps with the prior disability and is therefore attributable to the prior industrial injury, for which the employer is not liable.

(*Kopping v. Workers' Comp. Appeals Bd*. (2006) 142 Cal.App.4th 1099, 1115 [70 Cal.Comp.Cases 1229].)

In both 4664(b) and 4664(c), defendant is proving overlap. The difference between the two sections is that 4664(b) focuses on overlapping disability, whereas **4664(c) focuses on overlapping**

[5] In the past, courts have described application of section 4664(c) as "apportionment." (*Gordon v. County of L.A.* [2010 Cal. Wrk. Comp. P.D. LEXIS 581, *11-12].) The Appeals Board has also found that 4664(c) is not "apportionment." (*McGowan v. City of L.A*. [2015 Cal. Wrk. Comp. P.D. LEXIS 24 *7-8].) The issue is one of semantics that does not affect the analysis. Accordingly, we will use the term "application of section 4664(c)" throughout this opinion as referencing the process of calculating the application of section 4664(c).

body systems impacted by disability. This is an important distinction. Disability resulting from an industrial injury often differs from injury to a particular body part. However, substantial medical evidence must support those determinations.

Where defendant seeks to apply section 4664(c), and there is a dispute, defendant must do the following:

1) Establish a prior award(s) of disability.
2) Establish through expert medical evidence which body systems the prior disability affected.
3) Establish a current award of disability.
4) Establish through expert medical evidence which body systems the current disability impacts.

If applicant's disability spans multiple body systems, applicant may assign the disability to the body system that produces the highest rating.

The purpose of 4664(c) is to preclude accumulation of disability beyond 100% "with respect to any *one* region of the body." The overarching goal of rating permanent impairment is to achieve accuracy. (*Almaraz/Guzman III, supra,* 187 Cal.App.4th at p. 822) The Appeals Board has consistently held that when multiple methods can rate an employee's disability, they receive the higher rating. (*Ogilvie, supra,* 197 Cal.App.4th at p. 1277 [permitting rebuttal of the rating schedule with alternative higher rating based upon diminished future earnings]; see also *Grossmont Union High School District v. Workers' Comp. Appeals Bd*. (*Burns*) (1997) 62 Cal.Comp.Cases 687, 688 (writ denied) [establishing dual occupational rule, which allows for higher of two ratings when applicant's occupation spans two categories]; *Hartford Accident & Indemnity Company v. Workers' Comp. Appeals Bd*. (*Suttner*) (1990) 55 Cal.Comp.Cases 127, 128 (writ denied); see also *Dalen v. Workmen's Comp. Appeals Bd*. (1972) 26 Cal.App.3d 497, 506 [37 Cal.Comp.Cases 393]; *Weyerhaeuser Co. v. Workers' Comp. Appeals Bd*. (*Acosta*) (2003) 68 Cal.Comp.Cases 99, 100 (writ denied).) We see no reason to deviate from prior logic.

When a disability affects multiple body systems, a physician may assign it to either system and should assign it to the system that produces the higher rating. (See e.g., *Serrano v. GMC*, [2013 Cal. Wrk. Comp. P.D. LEXIS 28, *12-13] [Finding that 4664(c)(1) does not apply where fibromyalgia affected multiple body systems and not just applicant's upper extremities.].)

Here, the precise application of the statutory framework regarding the accumulation of permanent disability requires a granular medical categorization of impairments that is currently

absent from the evidentiary record. While the AMEs have extensively documented the profound physical and psychological deterioration of applicant, their reporting does not allocate these individual impairments into the strict anatomical regions mandated by section 4664(c)(1). The record shows that prior compensated awards involved the left lower extremity, right upper extremity, and cardiovascular system. The current claim involves overlapping pathology within these exact same physiological systems alongside newly claimed psychiatric and gastrointestinal impairments. However, the AMEs have not provided the necessary analytical bridge to determine which specific portion of the current overall occupational disablement belongs to each respective anatomical region. Without this explicit medical delineation, we cannot determine whether the disability for any single body region exceeds its lifetime maximum allowable rating. The AMEs must strictly assign both the prior functional deficits and the current functional deficits to their correct statutory categories to evaluate potential overlap.

Because the assignment of body systems overlap remains a strictly medical issue requiring scientific expertise beyond the purview of lay decision-makers, the evidentiary record requires further development. Return of this matter to the trial level is therefore essential for the parties to solicit supplemental expert opinions that explicitly parse the extensive medical and vocational impairments into their proper regional classifications. In light of our decision that such further expert medical opinion is necessary, we make no finding with respect to defendant's contention regarding apportionment per *Nunes I*.

V.

Section 3208.1 provides that an injury may be either cumulative or specific. No cumulative injury can occur without disability. (*Van Voorhis v. Workmen's Comp. Appeals Bd*. (1974) 37 Cal.App.3d 81, 86–87 [39 Cal.Comp.Cases 137]; *Aetna Cas. & Surety Co. v. Workmen's Comp. Appeals Bd*. (*Coltharp*) (1973) 35 Cal.App.3d 329, 342–343 [38 Cal.Comp.Cases 720].) A cumulative injury is one that occurs as "repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment." (Lab. Code, § 3208.1(b).) Section 3208.1(b) further provides that "[t]he date of a cumulative injury shall be the date determined under Section 5412." (*Ibid*.)

Section 3208.2 states that:

> When disability, need for medical treatment, or death results from the combined effects of two or more injuries, either specific, cumulative, or both, all questions of fact and law shall be separately determined with respect to

> each such injury, including, but not limited to, the apportionment between such injuries of liability for disability benefits, the cost of medical treatment, and any death benefit.

(Lab. Code, § 3208.2.)

The issue of how many cumulative injuries an employee sustained is a question of fact for the Appeals Board. (See *Coltharp, supra*, 35 Cal.App.3d at p. 341 [Applicant sustained two separate cumulative injuries, one before and one after the initial period of disability and need for treatment; to conclude otherwise would violate the anti-merger provisions of sections 3208.2 and 5303]; *Western Growers Ins. Co. v. Workers' Comp. Appeals Bd*. (*Austin*) (1993) 16 Cal.App.4th 227, 234–235 [58 Cal.Comp.Cases 323] [Applicant had one continuous compensable injury because, unlike *Coltharp*, his two periods of temporary disability were linked by the continued need for medical treatment and the two periods were not "distinct."].)

Harmonizing the holdings of *Austin* and *Coltharp* produce the following principles:

(1) If, after returning to work from a period of industrially-caused disability and a need for medical treatment, the employee's repetitive work activities again result in injurious trauma, i.e., if the employee's occupational activities after returning to work from a period of temporary disability cause or contribute to a new period of temporary disability, to a new or an increased level of permanent disability, or to a new or increased need for medical treatment, then there are two separate and distinct cumulative injuries that cannot be merged into a single injury (Lab. Code, §§ 3208.1, 3208.2, 5303; *Coltharp, supra*, 35 Cal.App.3d at p. 342); and

(2) If the employee's occupational activities after returning to work from a period of industrially-caused disability are not injurious, i.e., if any new period of temporary disability, new or increased level of permanent disability, or new or increased need for medical treatment result solely from an exacerbation of the original injury, then there is only a single cumulative injury and no impermissible merger occurs. (Lab. Code, §§ 3208.1, 3208.2, 5303; *Austin, supra*, 16 Cal.App.4th at p. 235.)

Here, a fundamental factual ambiguity remains unresolved concerning the etiology of the catastrophic systemic failures, specifically, whether they resulted from a new period of cumulative trauma or constituted compensable iatrogenic consequences of prior medical interventions attributable to prior injurious exposure. The medical evidence details a tragic sequence of events wherein routine therapeutic injections and surgical procedures introduced a devastating bacterial

infection into the bloodstream. The AMEs describe the subsequent emergency cardiac valve replacement and the neurological injuries sustained under anesthesia as direct consequences of treatment for the primary orthopedic condition. This medical cascade strongly suggests that the ensuing cardiovascular, neurological, and psychiatric disabilities represent adverse treatment outcomes stemming from the original injury, rather than a distinctly new period of repetitive workplace trauma. Although the AMEs reference overlapping dates of injury, they simultaneously attribute the totality of the severe internal and psychological decline to the infectious complications of the orthopedic surgeries. Furthermore, Mr. Vega's vocational reports conclude that applicant has lost all access to the open labor market, yet the combined effects of the surgical complications, rather than new workplace duties, caused this profound occupational exclusion. We must evaluate this evidentiary overlap to determine if applicant suffered a single, protracted period of injury linked by an ongoing need for medical care, or multiple separate injuries. Unfortunately, the current medical record falls short of this legal standard.

For example, during his January 26, 2023 deposition, AME Dr. Wertheimer clarified his apportionment analysis and ultimately determined that the various dates of injury overlapped and shared the same underlying causes. He acknowledged that his prior attempt to assign one-third of the disability to specific injuries and two-thirds to cumulative trauma was inherently speculative. He testified that the specific injury dates and the cumulative trauma periods overlap so heavily that attempting to separate them is simply not possible. He explained that the original injuries triggered an infectious medical cascade that was entirely responsible for the overall condition. As a result, any effort to divide the resulting disability among the three distinct dates of injury to a reasonable degree of medical probability would be nothing more than a gross estimate.

Similarly, AME Dr. Hyman echoed this diagnostic overlap in his assessment of the internal and neurological sequelae. While he meticulously detailed the timeline of the bacterial infection and the subsequent need for the emergency cardiac valve replacement, his reports do not adequately isolate the resulting functional deficits. Instead, he treated the internal decline as a direct continuum of the initial surgical complications. Like AME Dr. Wertheimer, AME Dr. Hyman concluded that assigning discrete percentages of internal disability to separate periods of trauma would be medically unsound given the cascading nature of the infection. However, acknowledging the catastrophic trajectory of applicant's decline is not a substitute for the rigorous analysis required to determine whether these internal injuries represent a legally distinct new cumulative trauma or a compensable consequence of the previous resolved cumulative trauma.

The psychiatric analysis provided by AME Dr. Greils presents a mirroring evidentiary deficiency. Evaluating the profound psychological impact of the medical cascade, he attributed the psychiatric disability to the aggregate trauma of the physical decline and the total loss of labor market access. Although his reports comprehensively outline the severity of the psychological condition, they fail to assign the psychiatric deficits strictly to their correct statutory categories. By tethering the psychiatric impairment to the inextricably intertwined physical conditions, he bypassed the necessary step of identifying the specific pathogenesis of the psychological injury. The medical record must clarify whether the psychiatric condition is a compensable consequence flowing directly from the surgical trauma or if it developed independently alongside a new period of cumulative trauma.

While the testimonies and reports of the AMEs established that providing an exact apportionment percentage based on current data is medically speculative, deeming the injuries inextricably intertwined does not cure the need to trace the specific pathological cause of the condition. To justify an unapportioned award or to evaluate overlap with accuracy, the medical evidence must bridge the gap between their findings of an intertwined medical cascade and the legal requirement to delineate functional deficits. Resolving this factual discrepancy is paramount because a finding that the latter impairments are merely compensable consequences of the initial medical treatment would fundamentally alter the requisite apportionment calculus. Consequently, we must return this matter to the trial level for a definitive factual determination on the number and nature of the injuries sustained, strictly guided by the AMEs outlining the origin of the systemic infections.

Accordingly, as our Decision After Reconsideration we rescind the WCJ's decision and substitute a new decision deferring issues related to permanent disability and attorney fees. We otherwise make no substantive changes to the decision.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the June 3, 2024 Second Amended Findings and Award is **RESCINDED** with the following **SUBSTITUTED** therefor:

FINDINGS OF FACT

1. Nerissa Watson, while employed during the period October 1, 2009 to January 1, 2011 as a Detention Services Officer, Occupational Group Number 490, at Los Angeles, California by the County of Los Angeles, permissibly self-insured, administered by Sedgwick Claims Management Services, Inc., sustained injury

arising out of and in the course of employment to her right wrist, right hand, left knee, heart and lungs, psyche, headaches, and gastrointestinal system.

2. At the time of the injury, the employee's earnings were $1142.54 per week.

3. Permanent disability is deferred.

4. Apportionment is deferred.

5. Applicant will require further medical treatment to cure or relieve from the effects of this injury.

6. Attorney fees are deferred.

AWARD

AWARD IS MADE in favor of Nerissa Watson against the County of Los Angeles, permissibly self-insured, administered by Sedgwick Claims Management Services, Inc., as follows:

1. Further medical treatment in accordance with Findings of Fact 5 above.

WORKERS' COMPENSATION APPEALS BOARD

/s/ CRAIG L. SNELLINGS, COMMISSIONER

I CONCUR,

/s/ KATHERINE A. ZALEWSKI, CHAIR

ANNE SCHMITZ, DEPUTY COMMISSIONER
CONCURRING NOT SIGNING

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

August 28, 2026

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

NERISSA WATSON
BURGIS & ASSOCIATES, P.C.
RK LAW WC, APC

DLP/md

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