ATTACHMENT A

THE PROPOSED DECISION

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BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Application for Industrial Disability Retirement of:

CHRISTINA S. MEDINA and CALIFORNIA STATE PRISON SOLANO, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, Respondents

Case No. 2021-0266

OAH No. 2021070275

PROPOSED DECISION

Marcie Larson, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on March 16, and August 30, 2023, from Sacramento, California.

Austa Wakily, Senior Attorney, appeared on behalf of the California Public Employees' Retirement System (CalPERS).

Richard E. Elder, Jr., Attorney at Law, represented respondent Christina S. Medina, who appeared at the hearing.

There was no appearance by or on behalf of respondent California State Prison Solano, California Department of Corrections and Rehabilitation (Department). The Department was duly served with a Notice of Hearing. The matter proceeded as a default against the Department pursuant to California Government Code section 11520, subdivision (a).

Evidence was received and the record remained open to allow for submission of closing and reply briefs. Closing briefs were received on November 8, 2023. CalPERS's closing brief was marked as Exhibit 29. Respondent's closing brief was marked as Exhibit KK. Reply briefs were received on November 22, 2023. CalPERS's reply brief was marked as Exhibit 30. Respondent's reply brief was marked as Exhibit LL. The record was closed, and the matter was submitted for decision on November 22, 2023.

ISSUE

At the time respondent filed her application for industrial disability retirement, was she substantially incapacitated from the performance of her usual and customary duties as a Dental Assistant for the Department based on her collar bone, right shoulder, and bilateral carpal tunnel (orthopedic conditions)?

FACTUAL FINDINGS

Procedural History

1. On November 27, 2019, respondent signed and thereafter submitted an application for industrial disability retirement (application) to CalPERS. Respondent requested an effective retirement date of May 1, 2018. At the time, respondent was

employed as a Dental Assistant for the Department. By virtue of her employment, respondent is a safety member of CalPERS subject to Government Code section 21151.

2. In her application, respondent claimed her specific disabilities were "impairment on range of motion caused by injury to collarbone [and] shoulder, limited hand strength caused by bilateral carpal tunnel." Respondent wrote that her injury occurred on February 25, 2015. Her bilateral carpal tunnel "stems from repetitive motion using hands while performing dental assisting." Her collarbone and shoulder injuries occurred during a "sally port gate" incident at the prison when an employee closed the gate and it "slammed" respondent while she was walking through the gate.

3. CalPERS obtained medical records and reports prepared by Chad Maclachlan, M.D., Philip Leroy Wagner, M.D., Rajpreet Dhesi, M.D., Nichole Chitnis, M.D., David L. Green, PhD, David P. Suchard, M.D., Toufan Razi, M.D., Am Krista Halal, NP, and Robert Henrichsen, M.D., who conducted an Independent Medical Evaluation (IME) of respondent concerning her orthopedic conditions. After reviewing the reports, CalPERS determined that respondent's orthopedic conditions were not disabling. As a result, she was not substantially incapacitated from the performance of her job duties as a Dental Assistant for the Department.

4. By letter dated August 24, 2020, CalPERS notified respondent that her application for industrial disability retirement was denied. Respondent filed an appeal and request for hearing with CalPERS by a letter dated September 17, 2020. She also provided additional medical information for CalPERS to consider.

5. By letter dated March 1, 2021, CalPERS notified respondent the additional medical information she provided was considered. CalPERS did not change

the determination to deny respondent's application. CalPERS informed respondent that her request for appeal would be set for hearing.

6. On July 6, 2021, Keith Riddle, in his official capacity as Chief of CalPERS's Disability and Survivor Benefits Division, signed and thereafter filed the Statement of Issues.

7. After the Statement of Issues was filed, respondent provided CalPERS additional medical information regarding her orthopedic conditions. By letter dated November 18, 2021, CalPERS notified respondent the additional medical information she provided was considered. CalPERS did not change the determination to deny respondent's application. CalPERS informed respondent that her request for appeal was set for hearing on January 22, 2022. Thereafter, respondent provided CalPERS additional information regarding her orthopedic conditions and the hearing did not occur.

8. By letter dated April 19, 2022, CalPERS notified respondent the additional medical information she provided was considered. CalPERS did not change the determination to deny respondent's application. CalPERS informed respondent that her request for appeal was set for hearing on May 11, 2022. Thereafter, respondent provided CalPERS additional information regarding her orthopedic conditions and the hearing did not occur.

9. By letter dated October 12, 2022, CalPERS notified respondent the additional medical information she provided was considered. CalPERS did not change the determination to deny respondent's application. CalPERS informed respondent that her request for appeal would be processed by the CalPERS legal office.

10. The matter was set for an evidentiary hearing before an ALJ of the OAH, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq. During the hearing, CalPERS amended the Statement of Issues to strike allegations that respondent failed to timely submit her application.

Respondent's Employment History and Work Injuries

11. Respondent worked as a Dental Assistant for the Department from approximately November 2003 until February 2015. Respondent worked full time and saw approximately 15 to 18 patients per day. In 2011, she began having bilateral carpel tunnel symptoms. She had two carpel tunnel surgeries in 2012 and 2013. She returned to work and performed her full duties after the surgeries. However, in 2015, she began having tingling and numbness in both hands.

12. At the end of February 2015, respondent was leaving work on a Friday. She was exiting the prison through a "sally port" metal gate. A correctional officer was operating the gate. As respondent passed through the gate, the officer closed the gate, which struck respondent on her right side at the base of her neck, her upper chest, and the midportion of her clavicle. She was twisted sharply to one side and had extreme pain at the point of impact. Respondent was "in shock."

Respondent went home. She was in pain through the weekend. She returned to the prison on Monday to complete forms reporting the incident. She did not perform any work that day. The same day, she went to Kaiser Hospital to be treated for her injuries. She has not returned to work for the Department since that day. She was 39 years old.

Duties as a Dental Assistant

13. As set forth in the Duty Statement, a Dental Assistant in respondent's position was required to perform duties including assisting the dentist performing dental examinations and various procedures on inmates, maintaining instruments and materials stock and inventories, ensures medical records are maintained including dental health history and consent forms are obtained, cleans, and disinfects surfaces and dental equipment.

14. On December 4, 2019, respondent signed a "Physical Requirements of Position/Occupational Title" form (Physical Requirements form). The Physical Requirements form was submitted to CalPERS. According to the Physical Requirements form, when working as a Dental Assistant, respondent: (1) constantly (over six hours a day) sat, stood, walked, bent, and twisted her neck, bent and twisted her waist, reached above and below her shoulders, pushed and pulled, engaged in fine manipulation, power and simple grasped, repetitively used her hands, carried up to 10 pounds, was exposed to excessive noise, and worked with biohazards; (2) frequently (three to six hours a day) used a keyboard and mouse and walked on uneven ground; (3) occasionally (up to three hours a day) kneeled, squatted, climbed, carried 11 to 50 pounds, drove, was exposed to extreme temperature, humidity, and wetness, was exposed to dust, gas, fumes or chemicals, operated foot controls or made repetitive movements, and used special visual or auditory protective equipment; and (4) never ran, crawled, lifted more than 50 pounds, or worked with heavy equipment.

Independent Medical Evaluation by Robert Henrichsen, M.D.

15. On July 28, 2020, at CalPERS's request, Robert Henrichsen, M.D., conducted an IME of respondent. Dr. Henrichsen prepared a report and testified at the

hearing consistent with the report. Dr. Henrichsen is a board-certified orthopedic surgeon. He obtained his medical degree from the Loma Linda University in 1967. Between 1970 and 1973, he completed an orthopedic residency at the Los Angeles Orthopaedic Hospital, Los Angeles County General Hospital.

Dr. Henrichsen practiced orthopedic medicine for approximately 50 years. He operated a private practice from 1973 until 2011, treating patients and performing surgeries related to orthopedic conditions. He is a fellow of the American Academy of Orthopaedic Surgeons. He has served as a Qualified Medical Evaluator (QME) for workers' compensation matters and as an Independent Medical Evaluator for CalPERS.

16. As part of the IME, Dr. Henrichsen interviewed respondent, obtained a medical history, and conducted a physical examination. He also reviewed the Physical Requirements form and essential functions for respondent's position. Additionally, Dr. Henrichsen reviewed respondent's medical records and reports related to her orthopedic conditions.

Respondent's Complaints and History of Treatment

17. Dr. Henrichsen obtained a history of respondent's occupational duties, orthopedic conditions, treatment, and present complaints. Respondent informed Dr. Henrichsen that she lasted worked as a Dental Assistant for the Department in February 2015, and has not worked in any capacity since that time. At the time of the evaluation, she was caring for her four-year-old grandson.

18. Respondent underwent a right carpal tunnel release surgery in May of 2012 and a left carpal tunnel release surgery in June of 2013. Following the surgeries, she was off work approximately three to four months. She returned to work

performing her full duties. By November 2014, she began having numbness in the left fourth finger.

19. In October 2016, respondent had right shoulder rotator cuff surgery. She continued to have pain and ultimately suffered from frozen shoulder. In May 2017, she had arthroscopic debridement on her right shoulder and release of adhesions. Her pain continued.

20. Respondent explained that she was not able to sleep on her right side. She suffered from daily pain. She has some twitching, catching, and clicking sensations in her right shoulder. She also had pain with motion and felt weakness in her right shoulder. Respondent used massage, acupuncture, and cupping therapy to reduce her pain. She also performed home exercises.

21. Concerning her wrists and hands, respondent had a burning feeling, which she feels more on the left than the right. She also has intermittent swelling. At times, she will have trigger fingers or thumbs that occur randomly. She also has pain in her palm. She sometimes wears a wrist orthosis, a medical device that restricts her range of motion. Both of her hands feel weak. She also cannot wear her jewelry due to swelling.

22. Respondent reported her average pain level was five to six out of 10. At times, her pain level was high as 10 out of 10. She experienced pain 100 percent of the time. Various activities aggravated her pain, such as writing, typing, lifting groceries, participating in social activities, standing, and walking.

Physical Examination and Review of Medical Records

23. Dr. Henrichsen conducted a physical examination of respondent, including a review of systems. The physical examination was limited to respondent's neck and upper extremities. Respondent's range of motion in her neck was reduced when looking down towards her chest and up toward the ceiling. Otherwise, her neck motion was normal. Respondent did not have muscle spasm or guarding in the neck. He also found no evidence of thoracic outlet compression syndrome, which is a compression of the nerves from the neck to the shoulder area.

24. Respondent was able to shrug her shoulders and abduct the scapula. She put forth more effort on the left than the right. She did not have scapular instability, which means that her scapula functioned normally against her ribcage when she moved her shoulders up and down. Dr. Hendrichsen explained that if there is a rotator cuff tear, then the muscles around the shoulder blades atrophy. Respondent did not have atrophy.

25. Dr. Hendrichsen used the O'Brien's maneuver, which loads the biceps tendons, on both shoulders. The right side produced diffuse anterior shoulder pain. There were no symptoms on the left shoulder. Dr. Henrichsen also used the Yergason's maneuver, which is a complimentary test to the O'Brien's maneuver. The Yergason's maneuver loads the biceps tendon in a different manner to see if the maneuver produces symptoms. Respondent had no symptoms on the left or right.

26. Dr. Hendrichsen also examined whether respondent had tenderness in and around the shoulder and the clavicle area. Respondent reported tenderness mostly at her collarbone joint to the shoulder blade, which is called the acromioclavicular joint (AC joint). The tenderness was consistent with arthritis.

Respondent's tenderness reduced around her sternum and the midline of her chest. He found no evidence of an injury to the brachial plexus, which is located beneath the clavicle area.

27. Dr. Henrichsen also evaluated respondent's mobility and right shoulder and rotator cuff strength. Her strength was normal. Her extension was normal, but flexion decreased when sitting more than when lying down. As a result, Dr. Henrichsen opined that respondent did not have a ligament contracture to limit her flexion, such as frozen shoulder. Rather she limited the flexion due to a self-imposed limitation. Her external rotation was normal, but her internal rotation was decreased.

28. Dr. Henrichsen also examined respondent's hands and wrists. He examined the tendons on the back of her hands and the palms to check for swelling. He found no swelling or evidence of tendon ruptures. Her wrist mobility was normal. He also found no evidence of tendon irritation or catching on the forearm tendons that go to the thumb, which can be a common area of irritation. He determined that the nerves that supply feeling to respondent's fingers were normal. Respondent complained of wrist pain, but Dr. Henrichsen found no objective evidence of wrist or hand abnormality for mobility and stability.

29. Dr. Henrichsen found some abnormality using the Tinel signs, which is involves tapping over the nerve at the wrist. Her right side did not produce symptoms, but she had symptoms on her left side in her palm and left ring finger. Dr. Henrichsen compressed the median nerve on both hands. The right side was not symptomatic, but respondent reported pain on the left side on her palm, which is "suggestive" that the "nerve is still a little irritated on the left." Respondent's hand strength was normal in both hands. He found no evidence of atrophy.

30. In his IME report, Dr. Henrichsen listed and summarized the medical records studies and reports he reviewed concerning respondent's orthopedic conditions. These records included records related to respondent's right shoulder surgeries. Dr. Henrichsen also reviewed reports referencing electrical and radial studies, including Electromyography (EMG) and Nerve Conduction Velocity (NCV) studies performed on respondent's upper extremities from the shoulders into the hand. There was no evidence of nerve damage from respondent's neck area down. There was also no evidence of cervical radiculopathy or ulnar nerve compression at the wrist or elbow.

Dr. Henrichsen explained that the NCV study measures the speed at which the nerve passes a message. Respondent's NCV study was abnormal because the conduction time of the median nerve across her wrist was slightly delayed. He explained the finding was consistent with respondent having previous carpal tunnel surgery. Not all carpal tunnel patients experience normal electrical studies after surgery. Dr. Henrichsen opined that this would not cause respondent any noticeable symptoms or affect her ability to perform her job duties.

Dr. Henrichsen also reviewed QME reports related to respondent's workers compensation claim for her orthopedic conditions. Dr. Henrichsen found no evidence in the medical records that respondent suffered from a brachial plexus injury due to the gate hitting her clavicle. An MRI scan of respondent's clavicle was normal. Dr. Henrichsen found no evidence of a thoracic outlet compression syndrome diagnosis in the medical records or studies performed on respondent.

DIAGNOSIS AND OPINIONS

31. Dr. Henrichsen diagnosed respondent with a history of "right and left carpal tunnel release with persistent left palm pain and subjective symptoms both hands"; three shoulder surgeries; "right shoulder frozen residuals with reduced motion and pain"; a "history of psychological issues"; and "[p]oor correlation between symptoms and findings." Dr. Henrichsen explained in part:

> My review of the available information indicates that regarding her shoulder, [respondent] has not been able to maintain the excellent repair accomplished by Dr. Maclachlan following the surgery of May of 2017 where the shoulder adhesions were released.
>
> [¶]...[¶]
>
> There is a lot of pain that is not supported by the clinical examination. She does not have atrophy about her parascapular muscles or rotator cuff, she does not have atrophy of her upper extremities, but there is pain and limited motion. She has better motion while supine than sitting which is common. She does not have specific nerve impingement from her neck, shoulder, wrist or elbow.
>
> There is no evidence of cubital tunnel syndrome or elbow dysfunction. In her wrist region, the right wrist and carpal tunnel release is not significantly symptomatic, although, there are lots of symptoms. On the left side, there has been some suggestion to examination that she may or may not

> have some residual carpal tunnel or recurrent carpal tunnel issues. However, her 2-point discrimination does remain within normal, she has no evidence of swelling of the digits, although she has symptoms of such. There is no examination finding of trigger thumb or trigger fingers, although, she explains those types of symptoms are present intermittently.
>
> [¶]…[¶]
>
> Therefore, as one steps back and looks at the issue, there [are] a lot of symptoms, and they are not well-supported by the examination findings and the hardcore examination findings are a little suggestive of some intermittent difficulty with the left carpal tunnel, but not the right and reduction motion of the shoulder because of pain symptoms or perceived pain.
>
> [¶]…[¶]
>
> My overall conclusion is again that there are lots of symptoms, there is not much in the way of supportive objective abnormal findings, and there is limited mobility with pain.

32. Dr. Henrichsen opined that respondent does not have an "actual and present impairment" or a "substantial incapacity to perform her duties" as a Dental Assistant for the Department. Concerning the performance of her job duties, Dr. Henrichsen explained:

> Regarding the quantitative physical requirement, if this position actually requires a person to have frequent reaching above shoulder, then she would have symptoms with the right shoulder, although she cannot reach that high, and in a dental office, there would not be much in the way of weight. Also, using the left arm to reach up more than the right arm would be a simple solution. I would suspect that in her work she would have symptoms when she does grasping or handling instruments, whether cleaning them or providing them to the dentist, but she would be able to accomplish those duties.

33. Dr. Henrichsen further opined that respondent "significantly reduced" her effort and "the medical records support that there is a large exaggeration of symptoms when compared to findings." Additionally, he opined based on his evaluation and review of records respondent "uses pain to allow reduction of motion and reduction of activity, rather than having mechanical limitation cause the reduction of function."

DECEMBER 2020 SUPPLEMENTAL REPORT

34. On December 18, 2020, CalPERS sent Dr. Henrichsen additional medical records to review, including a report from Jonathan Rutchik, M.D., and a Qualified Medical Re-evaluation report by David Suchard, M.D. CalPERS requested Dr. Henrichsen provide a supplemental IME report regarding his opinions and whether review of additional medical information changed his medical opinion about whether respondent was substantially incapacitated from the performance of her duties.

35. On December 18, 2020, Dr. Henrichsen issued a supplemental report. Dr. Henrichsen opined as follows in relevant part:

> My review of this additional information indicates that most healthcare providers had made decisions based on pain, tenderness and limited range of motion. The only new issue I identified was the summary from Dr. Suchard, regarding right sternoclavicular joint synovial hypertrophy, but it appears he did not consider it sufficiently significant to obtain an x-ray or CT scan of that joint.
>
> This new information does not change my prior opinions or conclusions. It remains my opinion that her perception of pain or that possibly she has fear that motion of her shoulder with pain will damage the shoulder joint, but there is no medical information to suggest that the latter is a remote possibility.

36. Dr. Henrichsen stated that his opinions were “unchanged.” He opined that respondent is “physically able to accomplish her occupational duties.”

OCTOBER 2021 SUPPLEMENTAL REPORT

37. On September 29, 2021, CalPERS sent Dr. Henrichsen additional medical records to review from 2015 through 2017, and a Progress Report by Joseph Centeno, M.D. CalPERS requested Dr. Henrichsen provide a supplemental IME report regarding whether review of additional medical information changed his medical opinion about respondent’s lack of substantial incapacity.

38. On October 1, 2021, Dr. Henrichsen issued a supplemental report. Dr. Henrichsen opined as follows in relevant part:

> Overall, my assessment of this situation is the same and that her perception of pain or fear of pain with motion of the shoulder will damage the shoulder joint. It can be seen that Dr. MacLachlan encouraged her, as did other providers to regain her shoulder mobility by stretching and then increase her strengthening. A variety of skilled physicians have examined her and not found any specific muscle weakness as persistent, there are no inflammatory issues, but pain is the basic problem, and now more recently in 2020, Dr. Centeno was again accomplishing MRI scans and considering differential injections. This same approach has been done before and the resultant two surgeries with reasonable range of motion, not much pathology was identified at either surgery and what little pathology that was present was treated, but yet the subjective result was unsatisfactory.

39. The additional information did not change Dr. Henrichsen's "prior opinions and conclusions." Dr. Henrichsen explained that it "remains [his] opinion that [respondent] does not have actual and present orthopedic inabilities to accomplish her occupational duties, pursuant to the job description that was supplied."

DECEMBER 2021 SUPPLEMENTAL REPORT

40. On December 29, 2021, CalPERS sent Dr. Henrichsen an MRI report completed on November 9, 2021. CalPERS requested Dr. Henrichsen provide a supplemental IME report regarding his opinions and whether review of the MRI report changed his medical opinion about respondent's lack of substantial incapacity.

41. On December 29, 2021, Dr. Henrichsen issued a supplemental report. Dr. Henrichsen opined as follows in relevant part:

> My review of this radiologic summary is that by imaging standard, there is some worsening of the rotator cuff. […] My assessment is that this is not a complete rotator cuff tear at this time and with the understanding that her work is mostly with the elbow below shoulder level and that she has had lots of right shoulder pain without an identifiable origin, it is my opinion that this new MRI scan does not change my prior opinions and conclusions and that she does not meet the CalPERS threshold of substantial incapacity for occupational duties.

42. Dr. Henrichsen further opined that respondent did not have an "actual and present orthopedic impairment." Her "function remains satisfactory to accomplish her occupational duties and she continues to have symptoms in excess of the overall examination findings."

FEBRUARY 2022 SUPPLEMENTAL REPORT

43. On February 4, 2022, CalPERS sent Dr. Henrichsen a letter requesting that he clarify his December 2021 Supplemental Report related to treatment respondent received for her right shoulder. CalPERS asked Dr. Henrichsen to confirm what period of time his records review included. CalPERS requested Dr. Henrichsen provide a supplemental IME report regarding his opinions and whether review of respondent's right shoulder treatment records changed his medical opinion about respondent's lack of substantially incapacity.

44. On February 10, 2022, Dr. Henrichsen issued a supplemental report. Dr. Henrichsen confirmed that he reviewed records from "May of 2017 to the conclusion of all records submitted to [him], which is November of 2020." Dr. Henrichsen confirmed that his opinions were unchanged.

SEPTEMBER 2022 SUPPLEMENTAL REPORT

45. On September 2, 2022, CalPERS sent Dr. Henrichsen respondent's medical reports from November 2021 to April 2022. These records referenced a plan for respondent to undergo an additional surgery on her right shoulder. CalPERS requested Dr. Henrichsen provide a supplemental IME report regarding his opinions and whether review of the reports changed his medical opinion about respondent's lack of substantial incapacity.

46. On December 9, 2022, Dr. Henrichsen issued a supplemental report. Dr. Henrichsen opined as follows in relevant part:

> My assessment is her shoulder function is reasonably good and well within the physical requirements of her

> occupational duties as a dental assistant. None of this additional information presents any medical summary that would indicate she does have substantial incapacity or that she does have sufficient shoulder issues that would prevent her from doing her work.

47. Dr. Henrichsen concluded that respondent's "right shoulder pain does not cause substantial incapacity for her work as a dental assistant."

FEBRUARY 2023 SUPPLEMENT REPORT

48. On February 23, 2023, CalPERS sent Dr. Henrichsen a February 14, 2023 IME Report prepared by Andrew K. Burt, M.D. CalPERS requested Dr. Henrichsen provide a supplemental IME report regarding his opinions and whether review of the IME report changed his medical opinion about respondent's lack of substantial incapacity.

49. On February 27, 2023, Dr. Henrichsen issued a supplemental report. He noted that Dr. Burt's evaluation found that respondent may have "brachial plexus pain from the injury." However, Dr. Henrichsen did not find any evidence of a brachial plexus injury in the "the medical records, nor it is again supported by objective examination and was not found on electrical testing." Dr. Henrichsen confirmed that his opinions and conclusions were unchanged.

Respondent's Expert Andrew K. Burt, M.D.

50. On February 2, 2023, at respondent's request, Andrew K. Burt, M.D., conducted an IME of respondent. Dr. Burt prepared a report dated February 14, 2023, and testified at the hearing consistent with the report. Dr. Burt obtained his medical

degree from the University of Nebraska in 1969. He performed an internship at Queen's Medical Center until 1970. He was a United States Air Force Flight Surgeon between 1970 and 1972. He then completed a general surgery residency. Between 1974 and 1977, he completed an orthopedic residency at the University of Nebraska.

Dr. Burt practiced medicine as a general practitioner from 1973 until 1982. Since 1982, he has worked exclusively conducting orthopedic disability evaluations with Doctors Industrial Medical Group, Inc. He has served as a QME evaluator for workers' compensation matters for the Department of Industrial Relations. He has performed approximately 20 CalPERS disability evaluations for applicants. Dr. Burt is not board-certified.

51. As part of the IME, Dr. Burt interviewed respondent, obtained a medical history, and conducted a physical examination. He also reviewed the Physical Requirements form and duty statement for respondent's position. Additionally, Dr. Burt reviewed respondent's medical records and reports related to her orthopedic conditions.

RESPONDENT'S COMPLAINTS AND HISTORY OF TREATMENT

52. Dr. Burt obtained a history of respondent's occupational duties, orthopedic conditions, treatment, and present complaints. Dr. Burt began the IME report related to respondent's "Narrative History" by stating that respondent had "labor-disabling orthopedic injuries in the course of her work for the State of California." These injuries included "some numbness and tingling in her wrists and hands sometime around early 2012." Within a month, she saw a physician and was ultimately diagnosed with "carpal tunnel compromise on both sides."

In July 2012, respondent had "right-sided carpal tunnel release produced little or no improvement in the symptoms." She returned to work after three months, but her symptoms persisted. In 2013, she had carpal tunnel release on her left hand. Again, she returned to work after approximately three months. Respondent reported "little to no improvement after the carpal tunnel surgeries and postoperative treatment." Respondent stated that "triggering developed at the long finger and ring finger on both sides." No additional surgery was recommended.

53. Respondent explained to Dr. Burt the injury she sustained in February 2015, when the right side of her neck and shoulder was hit by the sally port gate at work. She was taken off work by her physician and sent to physical therapy. She never returned to work.

In October 2016, she had right shoulder rotator cuff surgery. She reported "little or no improvement." She had second rotator cuff surgery in July 2017, again with "little or no improvement." She symptoms persisted at a "high level." She had a "third rotator cuff repair at the right shoulder along with debridement and ligament repair," performed by Dr. Centeno in late July 2022. Again, she reported "little or no improvement."

54. Respondent's current complaints included "pain at the base of the neck and over the trapezius area, more to the right side of the vertebral column." Pain with flexion and extension of her neck. She also reported "radiating pain to the area of the right shoulder blade, the upper back, and the anterior chest on the right side." "Pushing, pulling, and lifting" increased her symptoms. She also reported that "pain radiates with numbness and tingling in both hands and there is intermittent triggering of the long finger and the ring finger on both sides, more pronounced on the right."

Respondent explained that "at both wrists and hands, pain is located to the radial side aggravated by gripping, grasping, and torque activities." She reported "numbness and tingling" more on the "radial side." Respondent explained that she "tends to drop small objects such as coins, fasteners, or pills."

PHYSICAL EXAMINATION AND REVIEW OF MEDICAL RECORDS

55. Dr. Burt conducted a physical examination of respondent. Dr. Burt explained that the examination was "orthopedic in nature and limited to the area of her current labor-disabling symptoms, the cervical spine, the right dominant shoulder, left non-dominant shoulder, the right wrist and hand, the left wrist and hand, and the thoracic spine. Dr. Burt explained that he inspected respondent's "injured body parts and did a range of motion exercise, [and] tested for weakness." He also performed testing to determine if there was internal damage to respondent's shoulder joint.

56. Respondent complained of "tenderness to palpation at the base of the cervical spine and to the medial scapular border, left and right near the scapular spines." Her cervical spine range of motion was limited, and she complained of pain. Dr. Burt felt spasms in that area. For the "sensory examination of the upper extremities," Dr. Burt found "no dermatome pattern deficit or sensory loss to sharp stimulation with a pinwheel."

57. Respondent had reduced range of motion in her right shoulder. She complained of "pain at the base of the neck, the trapezius area, and anterior and posterior at the shoulder."

58. Concerning respondent's wrists, Dr. Burt found that the Tinel's sign was "positive on the right, negative on the left." Additionally, with "hyperflexion of both wrists, there was increased numbness and tingling in the median nerve distribution

(positive Phalen's test) more to the right." Also, with "abduction and external rotation of the right arm, the [respondent] complained of a sharp, shooting electrical-type pain extending from the base of the neck to the fingers on the right hand."

Dr. Burt found that respondent's "radial pulse disappeared (positive Adson's test)." Additionally, with the "Adson's maneuver on the left side, the symptoms were increased to a lesser degree." Respondent's "radial pulse disappeared with abduction and external rotation of the arm and she complained of increased pain and numbness into the hand." Dr. Burt also performed a hyperabduction maneuver, which was positive on both sides. He opined that in a "seated position with the hyperinflation maneuver of the lungs, the radial pulse disappeared on the right and she complained of increased pain, numb ness, and tingling in the hand." Additionally, the "radial pulse disappeared with the hyperinflation maneuver on the left, increasing numbness and pain." He opined that these findings are "compatible with bilateral thoracic outlet compression syndrome."

59. Concerning respondent's hands, she had "tenderness to palpation at the flexor tendons near the pulley area of the long and ring finger, left and right." She was able to demonstrate the triggering of the long finger and ring finger on the right side, accompanied by pain.

60. In his IME report, Dr. Burt listed and summarized medical records studies and reports he reviewed concerning respondent's orthopedic conditions. These included surgery reports, imaging studies, EMG and NCV studies, treatment records, Dr. Henrichsen's reports, and QME reports.

DIAGNOSIS AND OPINIONS

61. Dr. Burt diagnosed respondent with: Posttraumatic brachial plexus, neuropraxia, right side; Postoperative status arthroscopic debridement and rotator cuff repair, right dominant shoulder with distal clavicle excision; Postoperative status failed bilateral carpal tunnel surgeries (2012 and 2013); and Bilateral thoracic outlet compression syndrome. Dr. Burt suspected that respondent has an injury to her brachial plexus due to the trauma caused by the sally port gate hitting her clavicle area. He explained that his opinions are:

> Consistent with the history of cumulative and specific injury to the upper extremities and the chest wall on the right, brachial plexus involvement with direct trauma and subjective complaints long-standing numbness, particularly in the hands. The symptoms have been consistent with little or no improvement from conservative treatment and multiple surgical procedures at the shoulder, bilateral carpal tunnel surgeries.

62. Dr. Burt's diagnosis of thoracic outlet compression syndrome and brachial plexus, neuropraxia, was based on his clinical findings. He admitted there were no x-rays or the "electrodiagnostic studies" performed on respondent to support his diagnosis. He also did not disagree with the electrodiagnostic study performed on respondent in September 2020, which found no evidence for brachial plexopathy. However, he contended that electrodiagnostic studies did not conclusively rule out those conditions.

63. Dr. Burt opined that respondent is "unable to perform her usual job duties as a dental assistant due to substantial incapacity related to ungoing [*sic*] complaints at the neck and upper extremities." Additionally, he opined that respondent is precluded from "prolonged positioning, reaching, repetitive upper extremity work, pushing and pulling encountered in that job." Dr. Burt opined that respondent's substantial incapacity was permanent on February 26, 2015, when she was struck by the sally port gate.

Respondent's Testimony

64. Respondent does not believe she can return to work as a Dental Assistant for the Department. Respondent explained that after her carpel tunnel surgeries in 2012 and 2013, her wrist problems improved. However, by 2015, her she began having problems again. She had tingling in her hands and began dropping things because of numbness. Respondent claimed that she dropped instruments "every day" and that she would "frequently lose control." She felt "very unsafe because she was concerned that she would hurt someone with the sharp instruments." She wore wrist braces at night, with no improvement.

By 2019, she experienced tingling and burning sensation and "trigger finger," where her middle finger and ring fingers on both hands locked up. She had to manually open them. She has received steroid injections to help with carpel tunnel and trigger fingers. Surgery has not been recommended.

65. Respondent also explained that her right shoulder surgeries have not been successful. She cannot reach, pull, push, and or sleep on her right side because she has constant burning and stabbing pain in her shoulder. She has similar pain in her

right clavicle areas. She takes pain medication and muscle relaxers to deal with the pain.

66. Respondent's days consist of watching television. She is not motivated to do anything because her hands and shoulder hurt. She has "no strength to keep going." She tries to walk a half hour per day but has no other exercise regimen.

Analysis

67. When all the evidence is considered, Dr. Henrichsen's opinion that respondent was not substantially incapacitated from performing her duties as a Dental Assistant for the Department at the time she filed her application, was most persuasive. Dr. Henrichsen's opinions that respondent does not have an "actual and present orthopedic impairment" or a "substantial incapacity to perform her duties" are based on his review of respondent's duty statement, the physical requirements of her job as a Dental Assistant, review of her extensive medical records, reports, and studies and a physical examination. Dr. Henrichsen persuasively testified respondent's subjective complaints of pain do not rise to the level of substantial incapacity. The medical records support Dr. Henrichsen's opinions.

68. In contrast, respondent failed to present competent medical evidence to demonstrate she was permanently disabled or substantially incapacitated from the performance of her usual and customary duties as a Dental Assistant for the Department based on the applicable legal criteria, at the time she filed her application. Dr. Burt's opinion regarding respondent's inability to perform her job duties is primarily based on respondent's subjective complaints of pain. His diagnosis of thoracic outlet compression syndrome and brachial plexus, neuropraxia, which he

contends supports his finding of substantial incapacity, are not supported by respondent's voluminous medical records, nor the IME performed by Dr. Henrichsen.

Additionally, Dr. Burt's experience as a practicing orthopedic physician is extremely limited. He is not board-certified. He spent the last 40 years conducting disability evaluations, not treating orthopedic conditions. In total, Dr. Burt's opinions were given little weight.

69. When all the evidence is considered, respondent failed to establish that her industrial disability retirement application should be granted based upon her orthopedic conditions.

LEGAL CONCLUSIONS

1. Respondent seeks industrial disability retirement pursuant to Government Code section 21151, subdivision (a), which provides, in pertinent part, that "[a]ny patrol, state safety, state industrial, state peace officer/firefighter, or local safety member incapacitated for the performance of duty as the result of an industrial disability shall be retired for disability, pursuant to this chapter, regardless of age or amount of service."

2. As defined in Government Code section 20026:

> 'Disability' and 'incapacity for performance of duty' as a basis of retirement, mean disability of permanent or extended duration, which is expected to last at least 12 consecutive months or will result in death, as determined by the board, or in the case of a local safety member by the

governing body of the contracting agency employing the member, on the basis of competent medical opinion.

3. Government Code section 21152, subdivision (d), provides that an application for disability retirement may be made by the member.

4. Government Code section 21154 provides in relevant part that:

> The application shall be made only (a) while the member is in state service, or (b) while the member for whom contributions will be made under Section 20997, is absent on military service, or (c) within four months after the discontinuance of the state service of the member, or while on an approved leave of absence, or (d) while the member is physically or mentally incapacitated to perform duties from the date of discontinuance of state service to the time of application or motion. On receipt of an application for disability retirement of a member, […] the board shall, or of its own motion it may, order a medical examination of a member who is otherwise eligible to retire for disability to determine whether the member is incapacitated for the performance of duty. […]

5. Government Code section 21156, subdivision (a)(1), provides in relevant part that:

> If the medical examination and other available information show to the satisfaction of the board, […], the governing body of the contracting agency employing the member,

> that the member in the state service is incapacitated physically or mentally for the performance of his or her duties and is eligible to retire for disability, the board shall immediately retire him or her for disability, unless the member is qualified to be retired for service and applies therefor prior to the effective date of his or her retirement for disability or within 30 days after the member is notified of his or her eligibility for retirement on account of disability, in which event the board shall retire the member for service.

6. Incapacity from the performance of duty "means the substantial inability of the applicant to perform [her] usual duties." (*Mansperger v. Pub. Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876.) Substantial inability to perform usual duties must be measured by considering applicant's abilities. Discomfort, which makes it difficult to perform one's duties, is insufficient to establish permanent incapacity from performance of one's position. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, citing *Hosford v. Bd. of Admin. of the Pub. Employees' Retirement System* (1978) 77 Cal.App.3d 854, 862.) A condition or injury that may increase the likelihood of further injury, as well as a fear of future injury, do not establish a present "substantial inability" for the purpose of receiving disability retirement. (*Hosford v. Bd. of Admin.*, *supra*, 77 Cal. App. 3d at pp. 863–864.)

7. Findings issued for the purposes of Workers' Compensation are not evidence that respondent's injuries are substantially incapacitating for the purposes of disability retirement. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207; *English v.*

Bd. of Admin. of the Los Angeles City Employees' Retirement System (1983) 148 Cal.App.3d 839, 844; *Bianchi v. City of San Diego* (1989) 214 Cal.App.3d 563.)

8. The burden of proof is on respondent to demonstrate that she is permanently and substantially unable to perform her usual duties such that she is permanently disabled. (*Harmon v. Bd. of Retirement of San Mateo County* (1976) 62 Cal. App. 3d 689; *Glover v. Bd. of Retirement* (1980) 214 Cal. App. 3d 1327, 1332.) To meet this burden, respondent must submit competent, objective medical evidence to establish that, at the time of her application, she was permanently disabled or substantially incapacitated from performing the usual duties of her position. (*Harmon v. Bd. of Retirement*, *supra*, 62 Cal. App. 3d at p. 697.)

9. Respondent did not present competent, objective medical evidence to establish that she was permanently disabled or substantially incapacitated from performance of her duties as a Dental Assistant for the Department at the time she filed her industrial disability retirement application. Therefore, based on the Factual Findings and Legal Conclusions, respondent is not entitled to retire for disability pursuant to Government Code section 21151, subdivision (a).

ORDER

Respondent Christina S. Medina's application for industrial disability retirement is DENIED.

DATE: December 15, 2023

Marcie Larson

Marcie Larson (Dec 15, 2023 13:38 PST)

MARCIE LARSON

Administrative Law Judge

Office of Administrative Hearings