

**ATTACHMENT A**  
**THE PROPOSED DECISION**

BEFORE THE  
BOARD OF ADMINISTRATION  
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

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

SUZANNE LOWE,

Respondent,

and

DEPARTMENT OF CORRECTIONS  
AND REHABILITATION, CENTRAL  
CALIFORNIA WOMEN'S FACILITY

Respondent.

Case No. 2012 – 0801

OAH No. 2013040573

**PROPOSED DECISION**

Ann Elizabeth Sarli, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on November 21, 2013, in Fresno, California, and on July 10, 2014, in Sacramento California.

Jeanlaurie Ainsworth, Senior Staff Counsel, represented the California Public Employees' Retirement System (CalPERS).

Thomas J. Tusan, Attorney at Law, represented Suzanne Lowe.

Respondent Central California Women's Facility did not appear.<sup>1</sup>

Evidence was received. The parties filed closing briefs on August 25, 2014, which were marked for identification as CalPERS Exhibit 28 and respondent's Exhibit JJ. The matter was submitted and the record was closed on August 25, 2014.

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<sup>1</sup> Central California Women's Facility was duly served with a Notice of Hearing. The matter proceeded as a default against this respondent, pursuant to California Government Code section 11520, subdivision (a).

## PROCEDURAL FINDINGS

1. On May 25, 2007, Ms. Lowe filed a Disability Retirement Election Application for Industrial Disability Retirement (application), stating that she was unable to perform the duties of a Registered Nurse (RN) because of orthopedic injuries.
2. At the time Ms. Lowe filed her application she was employed as an RN by the California State Department of Corrections and Rehabilitation, Central California Women's Facility (CCWF). By virtue of her employment, Ms. Lowe is a state safety member of CalPERS, subject to Government Code section 21151.
3. CalPERS obtained medical reports concerning Ms. Lowe's medical condition from competent medical professionals and had Ms. Lowe evaluated by an orthopedist. On the basis of the medical evidence, CalPERS determined that Ms. Lowe was not permanently disabled or incapacitated from performance of her duties as an RN at the time her application was filed.
4. On April 2, 2008, CalPERS denied the application based upon the medical determination that Ms. Lowe's orthopedic conditions were not disabling.
5. Ms. Lowe wrote to CalPERS on May 9, 2008, requesting an appeal of the application denial. She wrote that she also wished to add fibromyalgia and chronic fatigue diagnoses to the application as bases for disability. She noted that the fibromyalgia and chronic fatigue diagnoses were made approximately a year earlier, in 2007. She wrote that she accidentally marked the application as an application for industrial disability, instead of as a disability application. At hearing, she maintained that she was mistaken in changing the application from industrial to non industrial disability and she wished to proceed with an industrial disability claim.
6. CalPERS made a determination to include the fibromyalgia and chronic fatigue syndrome as bases for the application.<sup>2</sup> CalPERS requested and received respondent's records from her rheumatologist and scheduled her for an examination by a rheumatologist, JaHahn Scalapino M.D., on February 24, 2009. Ms. Lowe's husband drove her from the Fresno area to Sacramento for this appointment. The letter setting up the appointment misdirected them to the wrong address and Ms. Lowe arrived 40 minutes late for her appointment. She presented at Dr. Scalapino's office and was told she needed to show her driver's license. She started back to the car to get the driver's license. She entered an elevator with two other passengers. The elevator suddenly halted, dropped a floor and a half and came to an abrupt stop. Ms. Lowe bumped her head on the side of the elevator. It took 20 minutes for the elevator repair crew to open the doors and extract Ms. Lowe and the two other passengers. Ms. Lowe reported to Dr. Scalapino that she had a lengthy car drive from Fresno, had been misdirected to the wrong office and had to drive another 40 minutes to get to Dr. Scalapino's office and then had been stuck in the elevator and bumped her head.

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<sup>2</sup> Exhibit 11.

The office manager called the building administrators and they insisted she fill out an incident report.

7. Ms. Lowe told Dr. Scalapino that the bump on the head exacerbated her nausea and her upper back myofascial pain. She told Dr. Scalapino she already had nausea and upper back myofascial discomfort from the long drive. Dr. Scalapino described Ms. Lowe's "unlucky drive from the Fresno area" in her report. She decided to conduct the examination despite the elevator incident, because she did not want to require Ms. Lowe to drive to the Sacramento area again and because she did not feel that the events in the elevator contributed significantly to her findings.

8. When CalPERS received Dr. Scalapino's report, staff was concerned that Dr. Scalapino may not have been objective, because of potential liability issues for the elevator incident and because Ms. Lowe had been injured in the incident and the injury may have affected the evaluation. CalPERS determined that Ms. Lowe should attend another IME with a different rheumatologist. Thereafter, CalPERS attempted to schedule Ms. Lowe for an IME with a rheumatologist. Ms. Lowe did not respond to several letters and attempts to schedule the IME. CalPERS wrote to Ms. Lowe on September 3, 2010, advising her that if she did not contact them within 14 days she will be deemed to have failed to cooperate and the application for industrial disability retirement would be cancelled. On October 11, 2012, CalPERS wrote to Ms. Lowe stating that because of her lack of cooperation, her disability claim for chronic fatigue and fibromyalgia had been dismissed and her appeal to the Office of Administrative Hearings would go forward on the basis of her claimed orthopedic injuries.

9. Ms. Lowe's counsel wrote to CalPERS on October 25, 2012, advising that Ms. Lowe did not intend to schedule or keep an appointment with another independent medical examiner, and that the issue of CalPERS's belief that Dr. Scalapino lacked objectivity or independence should be presented at the administrative hearing.

10. On February 11, 2013, Anthony Suine, in his official capacity as Chief, Benefit Services Division, Board of Administration, CalPERS, made the Statement of Issues and filed it thereafter. The matter was set for an evidentiary hearing before an Administrative Law judge pursuant to Government Code section 11500 et seq.

11. At hearing, after taking oral argument, the undersigned ruled that the application was based upon orthopedic conditions, but did not exclude fibromyalgia. The application explained in detail the extensive pain and suffering Ms. Lowe claimed she suffered throughout her body, symptoms which are consistent with fibromyalgia. The mere fact Ms. Lowe did not include the diagnostic label "fibromyalgia" did not preclude her from claiming disability due to fibromyalgia. Additionally, CalPERS acknowledged in writing that it was accepting the fibromyalgia and chronic fatigue syndrome claims as part of the application. (Exhibit 11)

12. At hearing, CalPERS argued that Ms. Lowe waived any right to assert disability based on fibromyalgia or chronic fatigue syndrome because of her failure to

cooperate with CalPERS's request that she attend a second IME with a different rheumatologist. The undersigned ruled that Ms. Lowe did not waive this right.

13. The undersigned also determined at hearing that the application is one for industrial disability retirement.

14. At hearing, CalPERS submitted medical records and reports from Kenneth Baldwin M.D., Frank L. Cantrell, M.D., and Douglas Haselwood, M.D., FACR, and Fresno Imaging Center. CalPERS also submitted an investigative report and video recording of Ms. Lowe and a Job Analysis for Registered Nurse at CCWF. CalPERS called Dr. Baldwin and Dr. Haselwood to testify. Ms. Lowe submitted medical records and reports from Dr. Scalapino, Dr. Cantrell, Richard G. Baker M.D. and David L. Kneapler M.D. Ms. Lowe called Dr. Scalapino to testify and she testified on her own behalf.

## ISSUE

The issue on appeal is whether at the time she filed her application for disability retirement, Ms. Lowe was permanently disabled or incapacitated on the basis of orthopedic conditions, chronic fatigue syndrome, fibromyalgia, or a combination of these conditions, from performance of her duties as an RN for CCWF. If disability is found to exist, any dispute as to whether the disability is industrial or nonindustrial will not be resolved in this forum, but will be resolved pursuant to Government Code section 21166.<sup>3</sup>

## FACTUAL FINDINGS

### *Injuries and Treatment*

1. Ms. Lowe began working for the State of California in approximately 1985. She worked in the Porterville Development Center for developmentally disabled patients from 1985 to approximately 1992, when she completed her RN degree. She then worked as an RN at the Corcoran prison from 1995 to 2000. She transferred to CCWF in 2000, and then

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<sup>3</sup> Government Code section 21166 provides:

If a member is entitled to a different disability retirement allowance according to whether the disability is industrial or nonindustrial and the member claims that the disability as found by the board, or in the case of a local safety member by the governing body of his or her employer, is industrial and the claim is disputed by the board, or in case of a local safety member by the governing body, the Workers' Compensation Appeals Board, using the same procedure as in workers' compensation hearings, shall determine whether the disability is industrial.

to the Department of Health for a year. She returned to CCWF and remained there until 2005, when she stopped working. She largely functioned as a triage nurse, evaluating and treating inmate medical problems.

2. Ms. Lowe had a long history of migraine headaches and took Imitrex. In November 8, 2000, Ms. Lowe was taken off work because of right wrist pain from writing. In December 2000, she was taken off work for right wrist "popping" after moving a box of charts. In January, 2001, she saw Dr. Cantrell, a neurologist, for neck and right upper extremity symptoms. In about August 2002, she was diagnosed with right elbow lateral epicondylitis, a common overuse syndrome of the extensor tendons of the forearm, after continuous writing for over nine hours. She was off work for a week. Dr. Cantrell precluded her from very heavy lifting and repetitive forceful gripping or grasping of the right upper extremity.

3. In 2003, Ms. Lowe was working in the prison emergency room when a heavyset woman who was post-laminectomy fainted as Ms. Lowe was assisting with her transfer. The patient fell on Ms. Lowe and she caught the patient with her right arm. Ms. Lowe felt low back pain and radicular pain to her right leg. She was treated conservatively and improved, though the pain continued to flare over subsequent months of work. She was off work for two to three weeks and had physical therapy and medication. The injury caused right lateral hip discomfort and aching in the cold and residual lateral toe tingling on the right.

4. Ms. Lowe reported to her physician that she continued to have symptoms in her neck, right arm, right leg and lower back. Her job duties required that she continue to write more than half of the day. The remainder of the time she was taking vital signs, preparing charts, screening and treating inmates, stocking supplies and equipment and performing procedures such as bandaging, and dispensing medication.

5. In May 2005, Ms. Lowe was pushing a heavy metal cart, which was laden with charts. She approached a heavy security door and held it open with her right hand while she tried to pull the cart over the threshold with her left hand. She felt a pop in the left mid-scapular region and shoulder and had a muscle spasm. She came back to work the next day but left early as the muscle spasm developed into a migraine. She did not return to work.

6. After this injury, Ms. Lowe received conservative treatment, chiropractic treatment and trigger point injections. Eventually, Ms. Lowe had a right lateral tendon release in March 2006. Ms. Lowe reported that the surgery did not help and actually resulted in more pain. Ms. Lowe had bilateral carpal tunnel release surgery in 2011.

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*Application for Industrial Disability Retirement*

7. In her application, Ms. Lowe identified her disability and its cause as follows:

Cumulative trauma injuries to right arm (including hand, forearm, elbow, upper arm, right shoulder and right side of neck). Cumulative trauma to the lower back, right hip and lower right extremity. Cumulative trauma to mid and upper back (including left shoulder, radiating to left arm, left side of neck). Due to prolonged periods of writing, lifting patients, pushing and pulling carts loaded with heavy medical charts.

Ms. Lowe identified her limitations as follows:

Unable to: (1) use upper extremities for repetitive activities as it causes muscle spasm; (2) sit or stand for long periods of time; (3) lift object/people; (4) react quickly to emergency situations; (5) think or focus clearly because of the muscle spasms and headaches they cause; (6) write or type for more than 10 minutes because of the pain from the muscle spasms.

Ms. Lowe explained that she was unable to perform her job duties as follows:

Unable to: (1) write or type for more than 10 minutes because of pain from the muscle spasms; (2) use upper extremities for repetitive activities as it causes muscle spasm; (3) sit or stand for long periods of time; (4) lift object/people; (5) react quickly to emergency situations; (6) think or focus clearly especially when in pain; (7) muscle spasms cause me to be tired easily.

Under the section entitled "Other information you would like to provide," Ms. Lowe wrote:

My life is changed significantly since these injuries. I am unable to perform my job duties as I once did due to pain. I am unable to enjoy many of the physical activities as I once did, due to pain and lack of energy. But not only have I been affected, so has my family and their lives. My husband and six children have had to adjust their lives to accommodate me, my pain and energy level. It has been hard on us all.

(Punctuation and stylistic changes made to aid readability.)

### *Videotape Surveillance*

8. Ms. Lowe filed her application on May 25, 2007. Chad Sandry, a Senior Special Investigator with the CalPERS Disability Validation Team, conducted videotape surveillance of Ms. Lowe on August 8, 2007, August 9, 2007, August 29, 2007, August 30, 2007, August 31, 2007, and September 7, 2007.

9. On Wednesday, August 8, 2007, Mr. Sandry arrived at Ms. Lowe's residence at 7:00 a.m. Ms. Lowe left her residence in her car at 7:30 a.m. He attempted to follow her and lost her in traffic. He returned to her home to watch for her return. He concluded his surveillance at 3:00 p.m. and she had not returned. Ms. Lowe was gone from home for at least seven and one-half hours.

10. The following day, August 9, 2007, Mr. Sandry began surveillance at Ms. Lowe's residence at 7 a.m. Ms. Lowe left the residence in her vehicle at 12:29 p.m. She drove to Liberty High School in Madera and arrived 18 minutes later. She walked inside the school office and emerged a few minutes later. She left the school and drove to Independence High School. She walked into the building and reemerged a few minutes later, got into her vehicle and returned to Liberty High School. She walked across the parking lot and into the building. She stopped and spoke with an adult male and shook his hand. She then walked to her vehicle, got into the vehicle and left the school with three children at 1:47 p.m. Ms. Lowe drove to a Subway restaurant and walked inside holding her cell phone with her right arm. She left at 2:33 p.m. carrying two large drink cups. She returned to Liberty High School, picked up a child and drove to an Arco gas station. She then drove to a Tire Supply store owned by her and her husband. Mr. Sandry concluded his surveillance at 4 p.m. Ms. Lowe was still at the Tire Supply store. This surveillance video shows Ms. Lowe continuously active for at least three and one-half hours. She got in and out of her vehicle repeatedly, walking briskly, holding keys and cups in her hands, shaking hands with a gentleman and waving at other persons and using her hands normally and briskly for movement such as putting up her hair. She was energetic and there was no guarding of any body part. She made significant use of her hands and arms during the videotaping.

11. On Wednesday, August 29, 2007, Mr. Sandry began surveillance at Ms. Lowe's residence at 2 p.m. Ms. Lowe left her house at 4:12 p.m. and dropped a child off at Liberty High school. She then went to the Fresno Imaging Center for an x-ray of her right shoulder and a cervical MRI. She emerged at 5:55 p.m., talking on her cell phone. She is seen carrying a phone in her right hand and a shoulder bag over her shoulder, and carrying keys in her left hand. She drops the keys from her left hand and bends with her right side to pick up the keys with her right hand. Once inside the vehicle she adjusted her seat and put her hair up. She drove 15 minutes to another location, walked upstairs and into an apartment, and left at 6:19 p.m. She drove to Sam's Club in Fresno and between 6:30 p.m. and 7 p.m., pushed a loaded cart around Sam's Club, and picked up and placed multiple items in the cart. She was constantly active, opening freezer doors, selecting merchandise, walking back and forth to the cart and placing items in the cart. She was repeatedly grasping, reaching and bending. She was constantly holding items and talking on her phone.

At one point her phone rang in the cart and she walked very briskly to the cart to pick it up. She walked and pushed the cart at a brisk pace. Her husband arrived at 6:39 p.m. and she continued to push the cart for several minutes until he took over. When they reached the checkout, Ms. Lowe spent about 13 minutes placing items on the checkout counter, using both arms and gesticulating. She walked over to an area of boxes and picked up empty boxes with both hands, readily bending and grasping them, and brought them over to the checkout counter. She wrote out a check and took the receipt. Her husband loaded the items into his truck and she opened the truck door with her right hand and easily climbed into the passenger seat.

12. The couple then went to Panda Express and left 22 minutes later with Ms. Lowe carrying a large soda cup and a to-go container. She got easily into the truck, and her husband dropped her off at the Sam's Club parking lot. She left and drove 20 minutes to Liberty High School where she waited in the parking lot, talking to others. She used her hands and arms easily and continuously. She waved at passersby and used her hands while she spoke to others. She generally held her hands above waist-level. At about 8:08 p.m., she placed her right arm on the top of a truck's open door and then idly swung the door back and forth. She drove off a minute later with a child and surveillance was concluded. Ms. Lowe had been active for over four hours; her movements were smooth without guarding. She used her hands and arm constantly, including her right shoulder, which she used to vigorously move a car door back and forth.

13. The following day, Thursday, August 30, 2007, Mr. Sandry began surveillance at Ms. Lowe's residence at 7 a.m. She arrived at the house at 3:37 p.m. and surveillance was concluded at 4:30 p.m. Ms. Lowe had not been at home for at least eight and one-half hours.

14. The following day, Friday, August 31, 2007, Mr. Sandry began surveillance at Ms. Lowe's home at 6 a.m. He did not observe any activity and he ended his surveillance at 11:30 a.m.

15. On September 7, 2007, Mr. Sandry began surveillance at Liberty High School, because Ms. Lowe's oldest son was on the football team and they had a scheduled game. Ms. Lowe and her husband arrived at 7:01 p.m. and stayed until 10:35 p.m. Mr. Sandry concluded his surveillance at 10:35 p.m. When they arrived, Ms. Lowe walked up the football field carrying two plastic bags and large plastic soda cup. She gave the bags to a female teenager and then walked downhill across a grassy hillside. She sat down in a camping chair on the grounds. During the next 27 minutes she remained seated talking to her husband and a woman to her right. During the entire time, her arms and hands were in constant motion. She gesticulated extensively when she talked and she was using a device to take photographs and films and to text. Her hands were in constant motion with the device. Most of the time her hands were at her chest level or above. She smiled and laughed and appeared comfortable in the chair. Often she held a large drink cup or what looked like a popcorn bag and ate and drank from them. Her hands would return to her lap very infrequently and remain there for a half a second to a second before she began using them

again. She often picked up a plastic bag and fished in the bag for items with her right arm and hand.

16. After about 29 minutes, everyone stood and did the Pledge of Allegiance. Ms. Lowe got up easily from her chair and clapped her hands after the Pledge of Allegiance. She sat down again and for the next hour and 15 minutes she sat, constantly moving her hands and arms to text, take photographs, gesticulate, and eat while talking to the person at her right. She laughed and clapped and appeared comfortable at all times. At 8:40 p.m., Ms. Lowe got up easily from her chair, put a jacket on and walked with a female at a good pace across a grassy area uphill. She walked to her car and it is unclear where she went after this, but 43 minutes later she returned down the hill carrying a large soda cup. She appeared to have no trouble walking and her pace was brisk as she walked through the crowd. She sat back down in her chair and remained there, constantly talking and moving her hands and arms, for about another half an hour. When she stood up to leave she stood up easily with a drink in her hands and grabbed for a bag, which her husband took. They walked into a crowded area where they remain standing several minutes while Ms. Lowe talked.

17. Ms. Lowe was active and energetic for at least three and one-half hours, and was able to sit for extended periods of time without needing to adjust her pose or stand. She was able to walk across an uneven surface and she had her hands and arms in constant motion and use.

18. At hearing, when asked to explain her activities on the videotape, Ms. Lowe explained that she cannot perform her job duties, but she is not "housebound" by her medical conditions. She can do many activities, but then finds herself in bed for two or three days. She did not offer further explanation.

#### *Testimony of Ms. Lowe*

19. Ms. Lowe last worked for the Department of Corrections in May 2005, when she was 43 years old. At CCWF she was required to see 40 to 200 patients per day. Often there would be overtime required. She had to hand-write chart notes, orders and other documents, often in triplicate. She had to open numerous large, heavy security doors throughout the day, with large heavy keys. Nurses were also required to push heavy metal carts, loaded with patient files from the main hospital, to each of four separate yards in the morning and then back in the afternoon. The total distance was approximately a quarter of a mile. She would need to open a door each time she saw an inmate. Toward the end of her employment at CCFW, the nurses were taking action to eliminate this duty, as custodial staff was never available to push or help push the carts.

20. Ms. Lowe started having physical problems in early 2001, to the point she saw a physician in 2002 for pain in her neck going down her arm. In 2003, she was helping a patient from a gurney when the patient fell on her. She felt numbness and pain in her low back and numbness down her right leg. She continues to have these back problems today. In May 2005, she was pushing a cart loaded with charts and came to the threshold of one of the

solid steel doors. She was trying to hold the door open with her left arm and while pulling the cart over the threshold with her right arm. She was yelling for help but nobody was around. She felt a pulling in her shoulders and her left shoulder “spasmed” up to the neck and down to the trapezius muscle. She returned to work the next day but not after that, because her employer could not offer light duty that did not require using her hands repetitively or lifting. Her condition has not improved since May 2005, but has gotten worse. She had surgery on her right elbow as well as left and right carpal tunnel release surgeries. These improved her conditions a bit. She has also had injections in her upper back which did not improve her condition, but worsened it. Currently she is taking Gabapentin, Sertraline and Tylenol with Codeine, which are prescribed by her rheumatologist for fibromyalgia.

21. Ms. Lowe testified that she cannot write for long periods of time, cannot sit for long periods of time and has a very difficult time moving from sitting to standing and trying to walk. When she is under a lot of stress she will be “down for three days,” and she is not able to handle stress well. She cannot seem to concentrate or focus and she gets tired very easily. She is not housebound but there are some events, such as her son’s state wrestling competition, that she could not go to because it required prolonged sitting and at the time of the event she was having difficulties and was in bed. She can perform simple tasks, like grasping a cup, but if she tries to write for a long time she has difficulty. If she was working as a nurse, she could not use her arms and hands to conduct physical examinations, push doors, help patients or write for very long.

#### *Evidence of Orthopedic Injury*

##### *Reports of Dr. Cantrell*

22. Dr. Cantrell is a neurologist who treated Ms. Lowe from 2001 through 2011. He placed her on temporary disability and issued reports for her workers’ compensation claim. On September 26, 2006, Dr. Cantrell wrote that when he last saw Ms. Lowe, on August 17, 2006 “it was very clear that she had a right biceps tendinitis with frozen shoulder and right flexor and extensor forearm myofascial pain.” He also noted that Ms. Lowe did not fit the diagnostic criteria for fibromyalgia, but had soft tissue injuries over the years. When he saw her in February 27, 2007, her last appointment before the August 2007 and September 2007 videotaping, she reported that “she continued to have pain in her shoulder and her neck and so forth.” He did not comment on her “frozen shoulder” but noted that at the time he was treating her for her right shoulder. On January 9, 2007, Dr. Cantrell noted that Ms. Lowe had pains which are “variable in location and do not seem to have a significant amount of objective correlate.” She told him she was taking Darvocet “occasionally.”

##### *Reports of Dr. Baker*

23. On October 9, 2007, one month after the September 2007 videotaping, Ms. Lowe was examined by Dr. Richard G. Baker, an orthopedist, in connection with her workers’ compensation claim. His report for the workers’ compensation system was

admitted in evidence as administrative hearsay. Ms. Lowe reported she had headaches stemming from her neck and shoulder pain which occurred every few days and lasted up to three days. She described pain traveling to the frontal region with associated nausea, blurry vision and lightheadedness. She described "daily and continuous" neck and upper back pain radiating to the shoulders and the scapular regions. The neck pain was not necessarily associated with activities. On a 5 out of 5 activity limitations scale, Ms. Lowe claimed that her neck and shoulder regions were a five for self-care, writing and typing; four for interference with physical activity and sleep, and three for interference with travel and a one with hand activities. Ms. Lowe said that her neck pain was 10 out of 10 on a scale of 1 to 10 and an eight or nine in associated areas. She reported her right elbow hurt continuously, with pain traveling up the arms to the neck. This pain was a 10. She described on-and-off numbness and tingling from the right elbow down and affecting primarily the first three digits and part of the fourth digit of the right hand. The right upper extremity imposed a 5 out of 5 interference with physical activity; 4 out of 5 interference with hand activities and sensory function, writing and typing; and a 3 out of 5 interference with self-care. Ms. Lowe stated that her right lower back hurt if she sits too long and reported a pain level of four to seven if she sits too long with a tingling in the right leg to the lateral toes. She estimated she can lift less than 10 pounds and can walk one block on a flat surface, 100 feet on hill. She estimated she could sit for two hours, drive for one hour, and do housework for up to 30 minutes. She could garden for about 30 minutes every other week.

24. Ms. Lowe described her work activities to Dr. Baker. One-third of the day including keyboarding, walking, forceful gripping, overhead reaching or lifting heavy patients. She could be required to stand up two-thirds of the day and had to do light gripping, reaching, twisting, stooping, bending, squatting, crawling pushing/pulling, kneeling and lift various objects up to 25 pounds more than two-thirds of the day. Dr. Baker also noted that Dr. Cantrell's records "do not necessarily support [Ms. Lowe's reports of] progression of increasing symptoms."

25. On the physical examination, Dr. Baker found no muscle spasm in the cervical, thoracic or lumbar spine. She reported tenderness in these regions. Motor strength of the neck was normal, back and abdominal strength were normal, and Waddell's test was negative. She reported tenderness in the right shoulder, and an impingement test was positive in the right shoulder. Upper extremity strength was normal. She reported diminished strength in the lower extremities. However, motor testing in the lower extremities was normal, Tinel's sign was negative over the major nerves in the upper extremities, Phelan's test was mildly positive on the right, seated straight leg raising was negative on both sides, and there was no clinical indication of upper or lower extremity complex regional pain syndrome. Straight leg raising produced reported low back pain on the right at 50 degrees.

26. Dr. Baker requested diagnostic studies. The cervical MRI demonstrated loss of lordosis at C7, a hemangioma (benign swelling or tumor) and a 3 to 4 mm bulge at C3-C4, abutting but not compressing the disc. The right shoulder radiographs were negative.

27. Dr. Baker diagnosed Ms. Lowe with chronic and recurrent cervical strain, right shoulder tendinitis/impingement, right elbow lateral epicondylitis status right lateral epicondyle release, right carpal tunnel syndrome and chronic lumbar sacral strain. He concluded that Ms. Lowe has chronic cervical strain with a small underlying disc protrusion at C3-C4, right shoulder tendonitis, right carpal tunnel syndrome and mild chronic low back condition. He noted that she did not have radiculopathy and electrical testing did not confirm radiculopathy or confirm carpal tunnel syndrome. However, current clinical findings were consistent with carpal tunnel syndrome. Dr. Baker concluded that Ms. Lowe was unable to perform her usual work due to the collective consequences of the various injuries. She was able to perform modified work with restrictions from lifting greater than 25 to 30 pounds, excessive bending or twisting of the neck, repetitive over the shoulder work with right upper extremity and right upper extremity grasping, pushing, pulling, torquing, and prolonged activities requiring repetitive digital dexterity.

28. Dr. Baker again examined Ms. Lowe on December 11, 2009, in connection with her workers' compensation claim. He noted that she had claimed she had no additional injuries since the last evaluation, but that according to Dr. Cantrell's April 21, 2009 record, there was "aggravation of neck and possibly of lumbar spine, right shoulder and right forearm stemming from an apparent elevator malfunction." He noted that Ms. Lowe acknowledged that her lifestyle was not completely sedentary, because she had four children ages 13 to 18. However, she did not engage in physical activities. She reported that her right arm had progressively worsened. She also tended to use her left arm in place of her right, and this had caused her to develop progressive symptomology in the left wrist and hand and worsening of the left shoulder. She also noted that her neck and upper back and shoulders had all worsened gradually. She indicated she was taking nortriptyline, ibuprofen, Darvocet and Aleve. She told the doctor that she had experienced migraines in the past that were resolved with Imitrex. She was again experiencing headaches, which traveled from the posterior to frontal part of the head and could last all day. The intensity was 10 out of 10 and she became lightheaded and nauseated and experienced blurred vision. She stated that she had neck and upper back pain all the time at a 9 out of 10 level and the pain radiated from the cervical-thoracic region and the neck to the shoulders as far as the mid-back and down the right arm into the forearm. She noted that her right elbow hurt all the time at an 8 or 9 out of 10, with swelling and with spasm. She reported pain in both wrists on a scale of 9 out of 10. She reported frequent back pain with tingling in the right leg, extended to the lateral toes. She stated she could lift 3 to 5 pounds, walk one block on flat surface, stand or walk for 30 to 45 minutes, drive for one to two hours, grocery shop for 30 minutes, do housework for 20 to 30 minutes, garden for 15 minutes and paint for 10 minutes. On physical examination he noted some reported tenderness of the cervical region, thoracic region or lumbar spine with no muscular guarding in the thoracic region. There was muscle guarding in the cervical region and the lumbar region and she reported tenderness in the cervical region, right and left shoulder girdle, thoracic region, lumbar region and right sacroiliac joint. Her motor strength of neck and back and abdominal strength were normal, there was no swelling in the wrists, although she reported tenderness over the bilateral carpal canal.

29. Dr. Baker noted that in the interval since her earlier examination, Ms. Lowe had developed left upper extremity problems and her explanation, that she was using the left upper extremity more for daily activities, was plausible. He recommended an agreed medical examination with a rheumatologist. He recommended an MRI for left intracranial disease to explore the cause for her headaches. Dr. Baker also recommended cervical and lumbar MRIs to determine if there were significant changes in pathologies from prior studies. He ordered plain bilateral shoulder radiographs to rule out bony or degenerative pathology, thoracic radiographs to rule out bone degenerative pathology and sacroiliac and right hip radiographs to examine levels of degenerative pathology.

30. Dr. Baker issued a supplemental report on January 20, 2010 in connection with Ms. Lowe's workers' compensation claim. He noted that the radiographs of the shoulders that he had requested had been performed and the studies were negative. The thoracic radiographs were performed and the radiologist described very mild marginal spurring at T 7-8, 9-10 and 10-11. The lumbar MRI was performed and the radiologist noted L4-5 disc desiccation without narrowing and a 3 mm disc bulge slightly eccentric to the left; L5-S1 decreased disc height and mild disc desiccation and a cyst within the spinal canal at S1 and S2. Sacroiliac radiographs noted a transitional lumbosacral segment with partial centralization on the left and the joints were normal. Right hip radiographs identified mild tendon calcification near the insertion of the great trochanter, but the study was otherwise negative.

31. Dr. Baker issued an additional report on December 1, 2011, in connection with Ms. Lowe's workers' compensation claim. Ms. Lowe told him that she worked approximately one to two hours per week for her husband's business, a tire company, performing paperwork. He noted that right carpal tunnel release was performed on August 1, 2011, and left carpal tunnel release was performed on September 22, 2011. She had benefited from the surgical procedures. She noted she was using Aleve. She had headaches a couple of times per week, lasting anywhere from 12 hours to couple of days, with pain radiating from her shoulders. She experienced nausea, fatigue and difficulty focusing. She reported continuing neck, upper back and bilateral shoulder girdle pain ranging from 3 to 10 out of 10. Once or twice-weekly pain traveled to the upper arms and to the right elbow and forearm and caused 10 out of 10 pain. Virtually anything increased the pain. She was able to reduce the pain by rolling on a foam support, using heat or by taking medication. Ms. Lowe also reported pain in the bilateral wrists and hands associated with the surgery site and low back pain "on and off." She estimated she could lift 15 pounds, walk one block on a flat surface, stand for 30 to 60 minutes, sit for 30 to 60 minutes, drive for three hours, grocery shop for 30 minutes and do housework for 15 minutes. She was able to bathe and dress, and to clean house with help from her three children who lived at home. She was able to engage in activities with her grandchildren. She described very recent difficulty climbing stairs, reaching or grasping at high level or above, pushing or pulling and grasping, holding or manipulating objects, repetitive motions, forceful activities, and bending and squatting. She was only taking Aleve and ibuprofen. She stated that roughly every two to three weeks she would feel good for two to three days and then have fibromyalgia pain. She was sleeping

during the day, because she did not get enough sleep when her sleep was interrupted by pain in one body part or another.

32. Dr. Baker noted on examination that there were no signs of complex regional pain syndrome, cervical lordosis was decreased, and there was no gross thoracic kyphosis. Thoracic and lumbar lordosis were normal. She was able to walk on toes and heels. There was no spasm in the cervical, thoracic or lumbar regions. Muscle guarding was present in the cervical region and lumbar region. Tenderness was reported in the cervical, thoracic and lumbar regions and the right and left sacroiliac joints and left sciatic notches. Motor strength of the neck was normal, and back and abdominal strength was normal. She reported tenderness in the muscles about the bilateral shoulders, but there was no tenderness directly in the joints. The bilateral shoulders were stable and impingement tests were negative on the right and left. There was bilateral thenar atrophy and she reported tenderness diffusely about the hips.

33. Dr. Baker concluded it was too soon, following the carpal tunnel release surgeries, to provide a final report rating her for the purposes of workers' compensation. Moreover, she had not had any treatment recommended for fibromyalgia.

34. Dr. Baker again examined Ms. Lowe April 21, 2013. He noted she had stopped working very part-time at her husband's business in January 2012, because it was difficult to continue to work due to fibromyalgia. She explained she had a mostly sedentary lifestyle. She said she had a small amount of benefit from the carpal tunnel surgeries, but later developed symptomology. Her fibromyalgia physician, Dr. Kneapler, recommended that she have light exercises and she joined a gym in April 2013, but it was too difficult to go four days week and she goes two days a week. She works out on a treadmill, is doing light weight 5 pound exercises, and recently began a yoga class. She was taking gabapentin, Zoloft and Tylenol with codeine. The Zoloft had been helpful with depression and sleep issues. She said she may be somewhat better than she was the last time he saw her 2012 due to treatment for fibromyalgia.

35. Ms. Lowe complained of continuous pain in her neck and her muscles were tight, with decreased motion and pain which traveled through the shoulders and upper back. Her arms hurt and she had continuous right lateral elbow pain and right wrist pain when she writes. Grasping was also painful. When she engaged in repetitive activity she experienced tingling in the fingers of her right hand. Her right hand was weak and she dropped things. She has daily pain in the low back of 7 out of 10 and pain in her left wrist and fingers. Her low back pain radiated to the hips and thighs. She reported that when she rises from sitting she has pain in her knees, ankles and feet. She needs help getting up. She reported great difficulty climbing one flight of stairs, some difficulty reaching or grasping to eye level or overhead, and difficulty with pushing, pulling, and gripping, grasping, holding, manipulating, and repetitive upper extremity activity.

36. On physical examination, Ms. Lowe's, head, carriage and cervical lordosis were normal, she had symmetric muscular development in the neck or back and shoulders

and the lumbar lordosis was normal. Her gait was normal and she was able to walk on toes and heels. Her upper and lower extremity ranges of motion were normal. There was a normal EEG and no signs of complex regional pain syndrome. There was no spasm in the cervical, thoracic or lumbar regions. Muscle guarding was present and she reported tenderness. Motor strength of the neck, back and abdomen were normal. She reported tenderness of the shoulders right lateral elbow and bilateral hip trochanters. Impingement testing was negative. There was no pain in the right wrist on extension or flexion

37. On October 30, 2013, Dr. Baker reviewed the medical records of Dr. Johnson, who had performed the bilateral carpal tunnel release surgery. Dr. Johnson had discharged Ms. Lowe from active care and opined that she could return to work without restrictions as of December 1, 2011. Dr. Baker agreed that Ms. Lowe did not have a disability based on carpal tunnel problems. However he noted that on May 6, 2013, Dr. Deshmukk reported that Ms. Lowe had noticed increased numbness and tingling in the right upper extremity, which was worse than the previous month. Dr. Deshmukk had performed bilateral upper extremity electro-diagnostic testing on June 24, 2013, finding a mild left carpal tunnel syndrome. Dr. Baker opined that from an orthopedic perspective, within the context of the workers' compensation system, there were no findings indicating cervical radiculopathy myelopathy. He precluded Ms. Lowe from heavy lifting. He noted that her lumbar condition precludes her from very heavy work because of the mild degenerative changes at L4-5 and L5-S1 and small disc bulge at L4-5. She would be restricted from lifting greater than 20 to 25 pounds and excessive bending or twisting of the back, bilateral repetitive over-shoulder work, right upper extremity repetitive grasping, pushing, pulling, and torquing. He noted she will not be able to do her usual and customary work.

*Report and Testimony of Dr. Baldwin*

38. Kenneth Baldwin is an orthopedic surgeon who was certified by the American Board of Orthopaedic Surgery in 1984. He attended medical school at Autonoma Universidad Guadalajara between 1972 and 1974 and then the University of California at Los Angeles School of Medicine (UCLA) between 1974 and 1976. He did his internship at the UCLA Department of Pediatrics and his residency at the UCLA Division of Orthopaedic Surgery. He performed a fellowship in South Africa in pediatric and trauma orthopedic surgery between July and December 1980. Dr. Baldwin had a private practice in orthopedic surgery between 1981 and 2004 and has an active but nonsurgical private practice since 2005.

39. CalPERS retained Dr. Baldwin to perform an orthopedic evaluation of Ms. Lowe on October 24, 2007, about six weeks after the sub-rosa videotaping was concluded. Dr. Baldwin noted that Ms. Lowe had a litany of complaints involving the joints of the upper extremities and she also claimed frequent headaches and inability to use the extremities due to periodic tingling in the arms. She did not report symptoms below the level of the low back. She was taking Darvocet and Nortriptyline. She was depressed and crying throughout the course of the evaluation and had moderate pain amplification of symptoms including moaning, exaggerated pain responses and non-physiologic pain behavior, mixed or

ambiguous. Range of motion was measured without guarding or spasm and muscle strength testing was performed without pain. Dr. Baldwin noted that Ms. Lowe demonstrated significant pain amplification during the course of the examination.

40. Dr. Baldwin noted there was voluntary restriction of the right shoulder, and the carpal tunnel evaluation was normal without a positive Phalen's test, Tinel's sign or altered sensation in the median nerve distribution. Dr. Baldwin reviewed Ms. Lowe's medical records. He concluded that the evaluation and his review of the medical records failed to substantiate her significant and exaggerated subjective complaints with evidence of objective findings. He reviewed the sub-rosa video and report of investigation. He noted that Ms. Lowe did not demonstrate visual evidence of substantial impairment which interfered with activities of daily living. He found she was capable of performing her usual job duties, there was no evidence of present disability, nor was there a suggestion that such a disability would develop in the future. He noted that her condition may make performing certain tasks difficult by causing some pain or discomfort, but there are no sufficient abnormal physical findings to suggest that she would be unable to perform the usual and customary functions of the actual and present job duties. There was no evidence that she would likely experience symptoms so severe as to preclude effective performance of job duties or to make further injury a medical probability.

41. Dr. Baldwin testified at hearing that Ms. Lowe's range of motion was normal in her neck, shoulder, elbow, arms, hands and back. She did not state any complaints as to her lower back when he saw her. The ranges of motion in the upper extremity joints and lower extremity joints were normal, aside from the shoulder, but Dr. Baker's measurements of shoulder range of motion had been within the normal range. He also testified he did not see any subjective complaints for which he would have recommended an examination for fibromyalgia. He testified that if Ms. Lowe had the impairment she was claiming, he would have seen it reflected in the upper and lower extremity movements on the sub-rosa videos.

#### *Discussion of Orthopedic Injuries*

42. At the time Ms. Lowe filed her application in 2007, she claimed extensive limitations in the use of her right hand, forearm, elbow, upper arm, right shoulder and right side of neck, lower back, right hip and lower right extremity. She claimed an inability to think or focus clearly because of muscle spasm and headaches. She claimed she was unable to write or type for more than 10 minutes because of pain from muscle spasm. She claimed she was unable to use her upper extremities for repetitive activities, because of muscle spasm, and that she was unable to sit or stand for long periods of time and she tired easily.

43. In the medical records from 2007, there was no medical evidence demonstrating that Ms. Lowe had muscle spasms. The medical records submitted in evidence do not document the presence of muscle spasm. In fact, Ms. Lowe's medical examinations document that muscle spasms were not noted on examination. There was no objective evidence of the physiological cause for the 10 out of 10 pain she reported.

Generally, her range of motion was normal and her neurological examinations were normal. She infrequently took medication for pain.

44. At this time, in 2007, Dr. Baldwin formed the opinion that Ms. Lowe was not substantially incapacitated from the performance of her job duties due to an orthopedic condition. He formed this opinion after he examined Ms. Lowe 2007 and after he had reviewed her medical records and the sub-rosa videotape. He confirmed his opinion at hearing.

45. Ms. Lowe relied upon the opinion of Dr. Cantrell to support her claim that she is disabled because of orthopedic injuries. However, Dr. Cantrell's reports were admitted as hearsay and he did not testify at hearing. Moreover, his reports did not identify any objective findings, but appeared to adopt Ms. Lowe's complaints. His opinion that she could not work was conclusory, was based upon her subjective complaints, and did not address substantial incapacity or permanency. Additionally, Dr. Cantrell made conclusions that were unsupported by the rest of the record. For instance, he noted in his September 26, 2006, report that when he had last seen Ms. Lowe on August 17, 2006, "it is very clear she had a 'frozen' right shoulder." However, x-rays did not confirm this and the sub-rosa videotape in 2007 shows full and unfettered use of the shoulder.

46. Ms. Lowe also relied upon the opinions of Dr. Baker to support her claim that she is disabled because of orthopedic injuries. Dr. Baker's reports were admitted as hearsay and he did not testify at hearing. He examined Ms. Lowe in the context of the workers' compensation law, and was focused on determining her impairment/disability ratings for her various injuries. Although he concluded that she could not return to work, he did not make a finding that she was substantially incapacitated from the performance of her job duties. Dr. Baker's opinions are not persuasive for additional reasons. He had not seen the sub-rosa videotape. His examination of October 9, 2007, was just a month after these sub-rosa videotapes were taken. At that time, Ms. Lowe had complained to him of pain traveling up her arm into her neck and down to her wrists, and on and off numbness and tingling from the right elbow down into the hands affecting the fingers, with weakness. She had also told Dr. Baker that her low back hurt when she sat for too long, and there was a tingling in the right leg. Had Dr. Baker reviewed the sub-rose videotape, it is arguable that his opinion regarding Ms. Lowe's ability to use her fingers would have changed. Additionally, Dr. Baker based some conclusions on medical evidence that did not support the conclusion. For example, he concluded that Ms. Lowe had preclusions in twisting, torquing, bending, sitting and standing and based these on MRI findings which did not show nerve impingement or show any findings except normal degenerative changes for a woman Ms. Lowe's age.

47. There was a lack of medical findings supporting Ms. Lowe's complaints of debilitating pain. Her complaints of pain were consistently on the highest end of pain scales. There were no significant findings on examination, radiology or MRI to support her claims. Her carpal tunnel syndrome resolved after her surgeries. In addition, Ms. Lowe's testimony was not persuasive. It is not logical that one would be able to function as well as Ms. Lowe did in the sub-rosa videotapes and be active many hours for consecutive days, and then

suddenly be struck with debilitating headaches, nausea, hand and arm pain and fatigue that would send her to bed for several days. It is true that most, if not all people who suffer chronic pain and disability have “good days” and “bad days,” and that many of them may be able to work for a day, but cannot tolerate the cumulative effect of working. Ms. Lowe does not appear to be one of these persons. She is able to cook, clean with some assistance, shop, walk, care for three to four children at home, sit for hours and keep her hands, arms and shoulders in motion for long periods of time. She infrequently needs to take pain medications, yet consistently claims that her pain is on the higher end of the pain scale. Ms. Lowe also did not support her testimony of extreme pain and disability with testimony from other witnesses who could attest to her pain or limitations.

48. In sum, Ms. Lowe did not meet her burden of proof by a preponderance of the evidence that at the time she filed her application in 2007, she suffered from permanent orthopedic conditions which substantially incapacitated her from the performance of her job duties.

#### *Evidence of Fibromyalgia and Chronic Fatigue Syndrome*

49. There was no medical evidence that Ms. Lowe suffers from the distinct medical syndrome called Chronic Fatigue Syndrome. It appears instead that the term was used in her medical records to refer to the fatigue component of the syndrome called Fibromyalgia.

50. The medical evidence pertaining to Fibromyalgia came from reports and testimony of Dr. Douglas Haselwood and Dr. JaNahn Scalapino, and a report of Dr. David L. Kneapler.

#### *Report of Dr. Kneapler*

51. A report of David L. Kneapler, M.D. AMC, dated March 14, 2011, was admitted in evidence as hearsay. Dr. Kneapler is a rheumatologist and pain specialist. He is board-certified in internal medicine. He examined Ms. Lowe in connection with her workers' compensation claim. She reported to him that she had widespread aching, beginning in 2006, and felt like she could not get out of bed. She said the widespread pain involved her spine, torso, arms, legs and pelvis, right elbow and the left side of her neck. She reported that when the left side of her neck bothers her, she develops headaches and has intermittent numbness and tingling of her hands. She reported that she feels tired during the day and has forgetfulness and word finding problems. Dr. Kneapler noted that fibromyalgia was a “derivative injury” as a consequence of Ms. Lowe’s orthopedic injury. He noted she will have permanent disability in spite of treatment.

#### *Report and Testimony of Dr. Scalapino*

52. Dr. Scalapino received her medical degree from the University of California at San Francisco. She did her internal medicine residency at Kaiser and finished a

rheumatology fellowship at the Mayo Clinic in Rochester Minnesota in 1985. She has been with the Sutter Medical Group since 1987 as a rheumatologist. She is board-certified in rheumatology.

53. Dr. Scalapino conducted a review of Ms. Lowe's medical records and examined her on February 24, 2009. Her report was admitted in evidence and she testified at hearing. Dr. Scalapino reviewed the sub-rosa surveillance tape and found that the activities caught on film "neither supported nor refuted her disability claims as they really do not correlate well to the activities she would be expected to do at work.... The tape was of generally poor quality and facial expression was not interpretable."

54. Dr. Scalapino examined Ms. Lowe, noting there was no evidence of autoimmune disease and that she moved easily. Ms. Lowe reported scattered areas of tenderness in the mid-cervical upper and mid-thoracic spine and in the upper and lower lumbar regions. She reported her sacrum and the sacroiliac joints and gluteal muscles were tender. She reported tenderness of the gluteal attachments on the trochanters right more than left. On examination, Ms. Lowe's cervical mobility was normal in flexion and mildly reduced in extension and moderately reduced in rotation, with normal tilt. Her lumbar mobility showed moderately decreased flexion but was normal in other planes. She reported had mild tenderness of the metacarpophalangeal joints, dorsal hands and both wrists but without loss of mobility. The right third proximal interphalangeal and distal interphalangeal joints were tender, and she reported tenderness about the right lateral elbow and diffusely in both shoulders. There was slight crepitus in the right shoulder tendon region anteriorly.

55. Passive hip motion was difficult due to Ms. Lowe's complaints of back pain and the doctor could bring her hips up to 90 degrees before she complained of low back discomfort. Ms. Lowe reported her knees were tender, but she moved completely and had good stability. There was no swelling or effusion in her ankles, which she reported were tender, but there was no evidence of actual inflammation. Her gait was normal, straight leg raising was limited by slightly tight hamstring and back pain, and she did not have radicular pain. Her deep tendon reflexes were of normal strength and sensation was intact except for subjectively slightly decreased sensation in the right fourth and fifth toes distally. Tinel's test was positive at the right wrist into the third finger and tapping at the cubital tunnel produced pain in the lateral epicondyle. Tinel's test was negative on the left at the wrist and elbow.

56. Dr. Scalapino concluded that "fibromyalgia is present today, or I suppose one could also call it a generalized pain syndrome but the term fibromyalgia is more conventional.... This resulted from her cumulative industrial injuries which caused chronic pain and most likely led to the development of the generalized pain syndrome that we called fibromyalgia."

57. Dr. Scalapino noted in her report that Ms. Lowe's right elbow discomfort due to lateral epicondylitis and myofascial pain had persisted even though she had been off work for several years and had undergone a surgical release in this area. Because the problems

persisted, Dr. Scalapino “suspected there would be more or less permanently variable discomfort depending on activity level.” The shoulder tendinitis which was bilateral at times, will vary depending on activity level and the cervical spine pain with radiation into the upper back was also worse with activity or prolonged sitting or driving. The low back pain and right leg discomfort was intermittent. Her lateral toe numbness did not have an anatomic correlation on the lumbar spine MRI.

58. Dr. Scalapino found Ms. Lowe disabled from her position as an RN because she is unable to lift or carry heavy medical records, write continuously over six to 10 hours a day in charts or maintain the alertness level and mental acuity necessary to protect herself and coworkers. This is due to a combination of her injuries and the effects of subsequent fibromyalgia. Dr. Scalapino found Ms. Lowe “presently substantially incapacitated for the duties required of her.” The incapacity would be expected to be permanent because she had been off work for nearly four years without substantial improvement.

59. Dr. Scalapino testified that the diagnosis of fibromyalgia is a “composite of what the patient says, what you find on examination, including palpations and excluding other conditions that might contribute to similar history and findings.” Ms. Lowe had widespread tender points consistent with fibromyalgia. Dr. Scalapino noted that it is not just the fibromyalgia that limits Ms. Lowe’s ability to do her duties as an RN, but chronic pain from fibromyalgia, from her low back, from her right lateral elbow, and from her neck and upper back. Her cognitive function as an RN is affected by the chronic pain. She is unable to be alert and attentive to safety at all times. Ms. Lowe also told her she was having cognitive problems and was unable to focus or concentrate, and it was clear she had some emotional lability issues that had been noted by other examiners. Dr. Scalapino’s general knowledge is that people with fibromyalgia or chronic pain syndrome are frequently bothered by extreme fatigue and cognitive dysfunction. Ms. Lowe’s physical limitations include lifting things, pulling heavy carts across thresholds, holding steel doors open, helping to resuscitate a patient, helping to lift a patient from the floor and helping with transfers. Dr. Scalapino testified that Ms. Lowe could not pull heavy carts without fear of exacerbating her pain

60. Dr. Scalapino’s diagnosis was based primarily on the diffuse tenderness and evidence of lateral epicondylitis around the right elbow and “that in and of itself ... [being] the dominant hand would make it very difficult to lift or even shake hands let alone lift chart of 2 pounds, let alone 20 pounds.” Moderate tenderness at the lateral elbow meant she could not lift 5 to 20 pounds. She could not write continuously over six to 10 hours per day in charts, because of the tenderness of the joints in her hands and her elbow and neck problems.

61. Dr. Scalapino testified that in reviewing Ms. Lowe’s records from her treating doctors in 2005 and 2006, “it was clear she was developing fibromyalgia or chronic pain syndrome stemming from her injuries...during that period of time she had tender points remote from the sites the original injury... The fibromyalgia developed in the latter part of 2005 to 2006 when it was noted she had widespread complaints of pain,” and there was no testing done to determine her alertness or mental agility. Dr. Scalapino noted that “one finds

fairly diffuse pain in fibromyalgia...she had widespread tenderness that one would not expect immediately from the bump on the head in an elevator.”

62. Dr. Scalapino testified that Ms. Lowe had problems in her dominant hand and shoulder that would have made it very difficult to write for long periods of time. “Once you have pain for a long enough time period, then it just becomes very difficult to even hold a pen and have legible handwriting.”

63. Dr. Scalapino testified that fibromyalgia is a “funny condition” and it is not known exactly what causes it but it seems to occur more often in young to middle-aged women and frequently occurs after one has had an injury resulting in chronic pain. Patients with chronic pain who developed a more diffuse chronic pain syndrome process pain differently from patients who were normal.

*Report and Testimony of Dr. Haselwood*

64. Dr. Haselwood received his medical degree from the University of Rochester, Rochester New York, and did an internal medicine internship and residency at the University of California Davis. He completed a rheumatology fellowship at the University of California Davis. He has had a private practice in rheumatology for 35 years. He is board-certified in rheumatology and a Fellow in the American College of Rheumatology.

65. Dr. Haselwood was unable to examine Ms. Lowe because she refused a further rheumatologic examination after her examination with Dr. Scalapino. He conducted an extensive medical record review. His report was admitted in evidence and he testified at hearing. He pointed out that the American College of Rheumatology has no objective criteria for diagnosis of fibromyalgia. Rather, the diagnosis is one of exclusion. The patient must report widespread pain for several months and widespread dysfunction including fatigue, cognitive difficulties and lack of restorative sleep. Then other conditions must be excluded. Other conditions include those which can cause musculoskeletal discomfort. If other conditions are excluded and the patient reports that she has severe and debilitating pain, then a fibromyalgia diagnosis can be made. The diagnosis of fibromyalgia thus is not based upon any objective criteria. Accordingly, one cannot simply take the diagnosis of fibromyalgia and infer that there are objective criteria upon which to measure the patient’s functionality. The diagnosis of fibromyalgia itself is not objective evidence of pain or of disability. The syndrome itself is determined by self reporting of subjective factors, and therefore it is very difficult for a rheumatologist to be able to determine objectively whether a patient is able to perform his or her job duties. There is no mechanism for offering objective criteria to determine severity and functionality in any individual.

66. Dr. Haselwood noted that Ms. Lowe had several orthopedic diagnoses and had been treated and evaluated for these orthopedic diagnoses. He noted that in the medical records he did not find evidence of measurable objective abnormalities that would preclude her from doing the usual and customary activities of her work as an RN. He confirmed the fibromyalgia syndrome diagnoses were based upon her subjective complaints only.

### *Discussion of Fibromyalgia Condition*

67. As Dr. Haselwood pointed out, there are no objective measures of the existence of fibromyalgia or the nature or extent of disability or functionality. Thus, one can expect there would be no objective medical evidence of disability accompanying a fibromyalgia diagnosis, although one might expect at least occasional muscle spasms and limited range of motion to appear in the medical records. However, the lack of objective medical evidence of disability does not preclude a disability claim. A disability claim can be substantiated by the credible subjective claims of the patient. But, here, as noted above in Findings 42 through 48, Ms. Lowe's complaints and her descriptions of her limitations were not persuasive and were not supported by any other evidence.

68. In addition, Dr. Scalapino's opinion was not persuasive. She had no objective findings of pain, limitation or cognitive dysfunction and relied completely on Ms. Lowe's reports. She emphasized that Ms. Lowe would suffer increased pain were she to resume her job duties, not that she was precluded from her job duties because of her physical condition or because the pain would prohibit her from working. She emphasized Ms. Lowe's cognitive decline and the dangers that would pose in her position. Yet there is no evidence of cognitive difficulties in any of the medical records, including the neurological medical records, and no evidence produced during the examinations. Her examinations did not document muscle spasms and in fact note the absence of muscle spasms. Dr. Scalapino discounted the sub-rosa videotapes, but it is clear she did not give them adequate attention. For instance, Dr. Scalapino testified that Ms. Lowe could not even hold a pen without severe pain. She clearly did not observe Ms. Lowe comfortably using a pen to write a check in the sub-rosa videotape at Sam's Club. Dr. Scalapino also testified that Ms. Lowe's right hand hurt so much even shaking hands would cause pain, yet the sub-rosa videotape shows her shaking hands with a gentleman and talking animatedly without appearance of pain, as well as clapping her hands during the football game and using her hands continuously for hours.

69. In sum, Ms. Lowe did not meet her burden of proof by a preponderance of the evidence that at the time she filed her application she suffered from fibromyalgia syndrome to the extent that she was substantially incapacitated from the performance of her job duties.

### **LEGAL CONCLUSIONS**

1. Ms. Lowe seeks disability retirement pursuant to Government Code section 21151, subdivision (a), which provides in pertinent part:

Any patrol, state safety, state industrial, state of 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. Government Code section 20026 provides that:

“Disability” and “incapacity for performance of duty” as a basis of retirement, mean disability of permanent or extended and uncertain duration, as determined by the board... on the basis of competent medical opinion.

3. “Incapacity for the performance of duty” under Government Code section 21022 [now section 21151] “means the substantial inability of the applicant to perform his usual duties.” (*Mansperger v. Public 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 ones 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. Board of Administration* (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. Board of Administration of the Public Employees’ Retirement System* (1978) 77 Cal. App. 3d 854, 863-864.) As the court explained in *Hosford*, prophylactic restrictions imposed to prevent the risk of future injury or harm are not sufficient to support a finding of disability; a disability must be currently existing and not prospective in nature.

4. An applicant for disability retirement must submit competent, objective medical evidence to establish that, at the time of application, he or she was permanently disabled or incapacitated from performing the usual duties of his or her position. (*Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697.)

5. 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. Board of Administration of the Los Angeles City Employees’ Retirement System* (1983) 148 Cal.App.3d 838, 844.)

6. The burden of proof is on Ms. Lowe to show that she is permanently and substantially unable to perform her usual duties such that she is permanently disabled. (*Harmon v. Board of Retirement of San Mateo County* (1976) 62 Cal. App. 3d 689; *Glover v. Board of Retirement* (1980) 214 Cal. App. 3d 1327, 1332.) Ms. Lowe has not met that burden, by virtue of the Factual Findings and Legal Conclusions.

7. Ms. Lowe is not permanently and substantially disabled or incapacitated from the performance of her job duties and, therefore, is not entitled to industrial disability retirement pursuant to Government Code section 21151, based on the Factual Findings and Legal Conclusions.

**ORDER**

1. Ms. Lowe's appeal of the CalPERS determination that she is not eligible for industrial disability retirement is DENIED.
2. Ms. Lowe's application for industrial disability retirement is DENIED.

DATED: September 1, 2014

  
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ANN ELIZABETH SARLI  
Administrative Law Judge  
Office of Administrative Hearings