

ATTACHMENT A
THE PROPOSED DECISION

BEFORE THE
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Involuntary Reinstatement
from Disability Retirement of:

DANIEL M. SOTO,

Respondent,

and

DEPARTMENT OF CONSUMER AFFAIRS,

Respondent.

Case No. 2013-0632

OAH No. 2013080482

PROPOSED DECISION

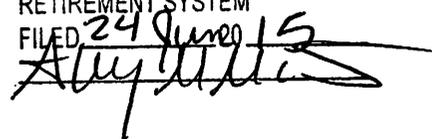
This matter was heard before Karen J. Brandt, Administrative Law Judge, Office of Administrative Hearings, State of California, on June 1 and 3, 2015, in Sacramento, California.

Preet Kaur, Staff Counsel, represented California Public Employees' Retirement System (CalPERS).

Daniel Soto (respondent) represented himself.

Barrett McInerney, Labor Relations Counsel, Department of Human Resources, represented respondent Department of Consumer Affairs (DCA).

Evidence was received on June 1 and 3, 2015. The record remained open to allow the parties to submit briefs. On June 8, 2015, CalPERS submitted its brief, which was marked for identification as Exhibit 26. On June 18, 2015, DCA submitted its reply, which was marked for identification as Exhibit G. The record was closed, and the matter was submitted for decision on June 18, 2015.



ISSUE

In or about October 2008, respondent applied for disability retirement. Respondent's application was granted, and he disability retired effective March 11, 2009. Because respondent was under the minimum age for voluntary service retirement, pursuant to Government Code section 21192, in 2013 CalPERS sent respondent for an independent medical examination. After reviewing the reports of the independent medical examiner, CalPERS determined that respondent was no longer substantially incapacitated from performing the duties of a Program Technician I.¹ Respondent appealed from CalPERS' determination. The issue for Board determination is whether CalPERS established that respondent is no longer substantially incapacitated from performing the usual duties of a Program Technician I.

FACTUAL FINDINGS

1. Respondent was born in 1965. He was employed by DCA as a Program Technician I. The last day he worked in that position was September 2, 2008.

Duties of a Program Technician I

2. As set forth in the DCA Position Duty Statement, a Program Technician I is "responsible for responding to telephone calls from departmental licensees and the general public." Eighty percent of a Program Technician I's duties involve working at the DCA Call Center, serving as the first point of contact for consumers and licensees, providing intake and screening of incoming calls to determine the appropriate level of assistance required, educating the public, providing licensees and consumers with referrals, and maintaining basic knowledge of the DCA boards and bureaus. Ten percent of a Program Technician I's duties include completing consumer publication requests. The remaining 10 percent of the duties consist of publication unit support.

3. The Position Duty Statement described the functional requirements of a Program Technician I as:

Daily access to and use of a personal computer and telephone.
Use of a computer mouse and minimal intermittent keyboarding (computer and phone keypad) is required (key data entry only; continuous typing not performed). Sitting and standing requirements are consistent with Call Center work. Motorized

¹ The Accusation originally identified respondent's classification as Program Technician III. At hearing, the Accusation was amended to correct respondent's classification to Program Technician I.

workstations and wireless or wire headsets are utilized to allow sitting, standing and mobility while working.

4. On October 6, 2012, a Supervising Program Technician III completed a Physical Requirements of Position/Occupational Title form for respondent's position. As set forth in that completed form, a Program Technician I never runs, walks, crawls, kneels, climbs, squats, bends at the waist, reaches below the shoulder, pushes, pulls, engages in power grasping, lifts, drives, or works with heavy equipment. A Program Technician I occasionally (up to three hours a day) stands, bends at the neck, twists at the neck and waist, reaches above the shoulder, and engages in simple grasping. A Program Technician I frequently (three to six hours a day) sits, does fine manipulation, and uses a keyboard and mouse. A Program Technician I constantly (over six hours a day) repetitively uses his hands.

Respondent's October 2008 Disability Retirement Application

5. Respondent submitted a disability retirement application dated October 15, 2008. In his application, respondent described his disabilities and their causes as follows:

R Shoulder 2003, chair broke, clavicle removed.

L Shoulder, torn rotator cuff, impingement, lapp surgery [sic], 2007 surgery.

7-2-07 – Neck, started with numbness in fingers, disc [illegible].

He described his limitations and preclusions as:

Headaches, migraines, unable to concentrate while working, ringing in ears, chronic pain, neck burns in pain. Hard to work a full 8 hour shift.

In response to the question asking how his injury or illness affected his ability to perform his job, he stated:

Due to pain. Can't take medication because they are narcotics and can't drive, DUI. The pain is getting worse.

In response to the question about whether he was currently working in any capacity, he stated:

9-2-08 – Last day worked. Work related injury. Bulged disc in neck hurts when doing computer work over 4 hrs.

He provided the following additional information:

This is permanent and it is getting worse with work – 8 hr shift
(modified, not going to be able to return full time.)

2009 Independent Medical Examination by Joseph Serra, M.D.

6. After receiving respondent's disability retirement application, CalPERS sent respondent for an independent medical examination to Joseph Serra, M.D., a board-certified orthopedic surgeon. Dr. Serra examined respondent on June 16, 2009, reviewed respondent's medical records, and issued an Independent Medical Examination report dated June 16, 2009. At the time, respondent was 43 years old. Respondent told Dr. Serra that he had sustained three industrial injuries: (1) in 2003, when a chair he was sitting in broke and he fell to the floor injuring his right shoulder; (2) in 2006 when he experienced pain in his shoulder due to overuse; and (3) in 2008, burning pain in both wrists, which respondent attributed to excessive keyboard use. Dr. Serra also noted that respondent developed migraine headaches and neck pain in 2008.

7. Respondent told Dr. Serra that his medical complaints were as follows: He had numbness and tingling bilaterally in his thumb, index and middle fingers. He experienced pain at the base of the "thenar eminence bilaterally."² He had persistent burning wrist pain bilaterally. He had "intense aching" and "occasional sharp pain" in his left shoulder. He could not sleep on his left side. He had constant burning pain in his neck, which was aggravated by driving, keyboard usage, and "most activities." His migraine headaches involved the orbit and the skull. His symptoms were partially relieved by the use of medication. He used splints, Jacuzzi and heat to decrease his wrist symptoms. On a scale of one to 10, respondent ranked his hand symptoms as a seven and his wrist symptoms as a 10.

8. During the examination, when examining respondent's ability to use his wrists and hands, Dr. Serra found:

Examination of the wrists reveals tenderness to palpation over the volar wrist crease. Tinel's test is positive. He is wearing cock-up wrist splints bilaterally. At night, he wears longer forearm and hand splints. Range of motion of his digits is normal bilaterally with fingertips touching the middle palmar crease with ease.

² As defined in the MedlinePlus online medical dictionary, the "thenar eminence" is the "ball of the thumb." <<http://www.merriam-webster.com/medlineplus/thenar%20eminence>> (as of June 18, 2015)

Jamar measurements of grip with three trials on the right major hand are 15, 15 and 10 kilograms. Three trials on the left minor are 20, 25 and 25 kilograms.

9. After examining respondent and reviewing his medical records, Dr. Serra diagnosed respondent as follows:

1. Status post surgery, right shoulder, for impingement syndrome and acromioclavicular arthritis.
2. Status post surgery, left shoulder for impingement syndrome.
3. Osteoarthritis glenohumeral joint, left shoulder.
4. Osteoarthritis carpometacarpal joints bilateral thumbs, mild.
5. Musculoligamentous strain, cervical spine, chronic.
6. Status post anterior cruciate ligament reconstruction right knee.
7. Migraine headaches per history.

10. Dr. Serra opined that respondent was “unable to perform the usual and customary duties of the call center which is 85 percent of the assignment for an 8-hour day.” Dr. Serra opined further that respondent “would be unable to utilize a keyboard for several hours due to the arthritis in the carpometacarpal joints of both thumbs and his postsurgical shoulder condition.” Dr. Serra found that respondent’s incapacity was “temporary,” and expected to last from “six months to one year.”

11. By letter dated September 8, 2009, CalPERS notified respondent that his disability retirement application had been approved.

2013 Independent Medical Examination by Gerald Barnes, M.D.

12. In 2012, in accordance with Government Code section 21192, CalPERS began re-evaluating respondent for continued qualification for disability retirement. CalPERS sent respondent to Gerald Barnes, M.D., a board-certified orthopedic surgeon. Dr. Barnes graduated from medical school in 1965. He has been licensed as a physician in California since 1967. He retired from full-time surgical practice in 1999. He has been an independent medical examiner since 1980.

13. March 16, 2013 Independent Medical Examination Report. Dr. Barnes examined respondent on March 15, 2013, reviewed respondent's medical records, and issued an Independent Medical Examination report on March 16, 2013. Respondent was 47 years old at the time of the examination.

14. During the examination, respondent described his 2003 fall from a chair while at work. He stated that he tore all the ligaments in his right shoulder when he fell. He had surgery on his shoulders on two occasions, and had pain in his shoulders every day. He rated his "every day" shoulder pain as a seven on a scale of 10, but asserted that when he used his arms, he had "stabbing, shooting pain" in both shoulders. Respondent complained of neck pain, rating it as a seven on a scale of 10, increasing to a nine when he lied down. He complained of pain and numbness in his hands and stated that all his fingers were numb. He described a procedure he had on his right thumb. In 2010, he had pain in his left elbow, and underwent surgery. He also had surgery on his wrists. He asserted that the surgeries on his wrists were not successful, but, instead, made his hands worse. He complained about daily pain in his low back, and pain in his feet.

15. Dr. Barnes noted that, during examination, respondent appeared to be "in discomfort in any position, with facial grimacing and paucity of use of all of his extremities." Due to complaints of pain, respondent was reluctant to move his shoulders, rotate his arms, or use his fingers. He stated he could not do a heel-and-toe walk due to the pain. In addition, while respondent had full range of motion in his fingers, he "gave a very weak finger squeeze on both sides, so no attempt was made to use a Jamar dynamometer."

16. After examining respondent and reviewing respondent's medical records, Dr. Barnes listed the following as his impressions:

1. Cervical myofascial pain syndrome,
2. Cervical spondylosis,
3. Lumbar spondylosis,
4. Migraine headaches by history,
5. Status post surgery both shoulders, for what sounds to be impingement syndrome,
6. Status post cubital tunnel surgery, left elbow,
7. Status post carpal tunnel surgery, both wrists,
8. Status post arthroplasty of the right thumb basilar joint,

9. Status post anterior cruciate ligament repair of the right knee,
10. Status post excision of cyst of the right foot, and
11. Chronic low back pain syndrome, probably related to lumbar spondylosis.

17. In his report, Dr. Barnes stated that it was “hard to understand some of the progression of [respondent’s] conditions and his inability to work.” Dr. Barnes noted that respondent had “surgeries to both wrist areas, his left elbow, and his right thumb area” since Dr. Serra’s independent medical examination in 2009. Dr. Barnes stated:

It is very difficult to understand everything that this individual has undergone. Every procedure he had so far as he is concerned, has made his condition worse. In spite of electrodiagnostic studies stating that he did not have any median nerve pathology, he still had carpal tunnel surgery on both wrists and he stated, he is worse after surgery. On examination it was very difficult to determine, as far as objective factors, exactly what was present, because subjectively his pain is such that he does not allow examination of his extremities and limited his response to requests for demonstration of range of motion, once again because of pain. By facial expressions, he actually showed what appeared to be discomfort when asked to do various movements of his extremities. On one occasion he even had to get up from the supine position. He requested to stand because he was having pain in his back. The issue of migraine headaches goes beyond my expertise, but apparently this has been another situation for which he declares disability.

18. Dr. Barnes opined that he could “identify no job duties that could not be performed by [respondent], but rather they could be performed with considerable difficulty.”

19. Dr. Barnes opined that respondent was not substantially incapacitated from performing his duties as Dr. Barnes understood them. According to Dr. Barnes, respondent’s complaints were of a “subjective nature.” But Dr. Barnes noted that he did not have records relating to respondent’s surgery on his wrists for carpal tunnel syndrome, his left elbow for cubital tunnel syndrome, or his right thumb. Dr. Barnes stated that his opinions were subject to change pending review of additional records. Dr. Barnes also noted that:

There is exaggeration of most of his symptoms. Also, I believe that he could put forth more effort than he displayed in the performance of the various movement that were requested of him. He had grimaces on his face during the examination,

suggesting he was having pain. Of course, once again, this is subjective, and it is very difficult for this examiner to deny. One observation, however, is that at the completion of the examination he had a fluid movement in taking off his examining gown and putting on his clothes, without apparent difficulty to suggest limitation or pain of his upper or lower extremities.

20. On April 27, 2013, CalPERS notified respondent that a “careful review of the medical reports and other information” indicated that he was no longer substantially incapacitated from performing his job duties. By letter dated May 2, 2013, respondent appealed from CalPERS’ determination. In his appeal letter, respondent, in relevant part, stated:

Dr. Barnes did not do any evaluation/test on my left or right hands. I never denied any test in the exam. (I said oh that is going to hurt. Hand squeeze thing). Dr. Barnes said oh well then we won[']t do it. I have a report dated 2012 signed by Dr. Clifford on 4/12/12. I am still incapacitated, and this is permanent. I have arthritis, and it is getting worse. I have two surgery’s [*sic*] pending, Left shoulder, titanium shoulder replacement, and C4 C5, bulging disc replacement (cadaver bone replacement). I am seeking therapy because I do not want to do surgery yet, due to two possible outcomes of the surgery that I have been informed of.

21. May 28, 2013 Supplemental Report. CalPERS asked Dr. Barnes to review additional medical records relating to respondent. On May 28, 2013, Dr. Barnes issued a Supplemental Report. Dr. Barnes noted that the last medical record that he reviewed for his March 16, 2013 Independent Medical Examination report was issued on October 21, 2009, by Dr. D’Amico, who summarized the results of the examination he conducted on respondent’s shoulder as follow: “Fairly good range of motion, almost 90 degrees of passive motion, active motion is 80 to 90 degrees without much discomfort. The pain is not severe and not steady. I do not think he is a candidate for surgery.”

In his May 28, 2013 Supplemental Report, Dr. Barnes summarized the additional medical records he reviewed, which were for the years 2010 through 2012. Based on his review of the records, Dr. Barnes stated that respondent had an “inordinate amount of operations dating back to when he was approximately 35 years old.” Dr. Barnes opined that respondent was not substantially incapacitated from performing his usual duties. As Dr. Barnes explained:

... based on my examination review of the records, his job duty description, and the new medical records provided I can identify no job duties that I feel [respondent] is unable to perform

because of an orthopedic physical condition but rather they could be performed with considerable difficulty. I stand by that opinion. However, there are plenty of indications in the medical records that [respondent] does have mental difficulties which may cause him some problems at work, however that is outside my specialty. I have nothing else to add at this point.

22. August 7, 2013 Supplemental Report. CalPERS requested that Dr. Barnes review additional medical reports for the year 2013. On August 7, 2013, after reviewing the additional reports, Dr. Barnes issued a second Supplemental Report. Dr. Barnes noted that in a medical record dated October 20, 2010, Dr. Todd James Winters, respondent's treating physician, had seen respondent for a Department of Motor Vehicles (DMV) physical so he could get a Class C license to drive a pool truck. Dr. Winters described the results of the physical as "musculoskeletal generally full range of motion of his shoulders with good grip strength." Dr. Barnes commented that he found "this interesting in that to drive a truck would require considerable dexterity and strength in the use of the upper extremities." Dr. Barnes opined that:

Although I do feel he has some difficulties in carrying out activities of standing, walking, squatting, reaching over and below shoulders, pushing and pulling and lifting and carrying 1-10 pounds, it is my opinion that he is able to perform these activities.

Dr. Barnes clarified his earlier opinion that respondent could perform the usual duties of his job with "considerable difficulty" by explaining that:

As I read the rules as stated in the Medical Qualification for Disability Retirement, there is one paragraph that answers what my decisions are based on: the second paragraph, "The law distinguishes between a person who suffers some impairment and one who suffers impairment sufficient and becomes eligible for disability retirement." I do feel that he does suffer some impairment, but not sufficient enough to make him eligible for disability retirement. It goes on to say and once again this is part of my decision, "Difficulty in performing certain tasks alone is not enough to support a finding of disability. It is the inability to perform the essential functions of the actual job duties that determines whether the member is substantially incapacitated for the performance of those job duties." It goes on to state, "Disability is not necessarily an inability to perform fully every function of a given position. Rather, the courts have concluded the test is whether the member has a substantial inability to perform the usual duties of that position. If the member cannot substantially perform the duties of that position,

the person is disabled for CalPERS retirement process. Otherwise, the member is not disabled.” This is the basis of my decision. I do feel that he has some impairment, but not sufficient impairment to render him substantially incapacitated. As far as the issue that [respondent] continues to put forth, the thing that is most difficult for me to deal with is that [respondent] retired himself in July 2007. It is my orthopedic opinion [respondent] is not substantially incapacitated.

Dr. Barnes noted further that there was “incapacity, but not enough to satisfy the ‘substantial’ requirement.”

Dr. Barnes’ August 7, 2013 Supplemental Report noted that respondent had asserted that Dr. Barnes’ failure to have him use a Jamar dynamometer precluded Dr. Barnes from rendering a medical opinion as to the disability of his hands. In response, Dr. Barnes stated that, in the March 16, 2013 Independent Medical Examination report:

... I said he had essentially full range of motion; however, he gives very weak finger squeeze on both sides, so no attempt was made to use a Jamar dynamometer. I do not believe [respondent] really understands and I do not expect him to understand, what a Jamar dynamometer is and what it actually measures. The reason I said there was no reason to use a Jamar dynamometer is because when the examiner’s fingers were offered to [respondent] and I asked him to squeeze the fingers, the grip was so weak that there would be no validity in the results of him squeezing the Jamar dynamometer, in fact the indicator on the device would not move. The test measures grip strength; however, you have to be able to squeeze the Jamar dynamometer sufficiently to measure. Besides that, the test is purely subjective in that a person can squeeze or not squeeze as hard as he feels like. It does not necessarily have validity as an objective test.

Dr. Barnes also explained that there was “ample evidence indicating [respondent] does not have sufficient disability as it relates to his shoulders based on any organic findings as stated by the various examiners that have seen him.” In particular, Dr. Barnes pointed to respondent’s shoulder surgeon, who opined that respondent had “ample range of motion to carry out the functions that his job would call for.”

23. October 8, 2013 Supplemental Report. On October 4, 2013, CalPERS forwarded additional records regarding respondent from 2013. On October 8, 2013, Dr. Barnes issued a third Supplemental Report. In this report, Dr. Barnes noted that he had totaled up the number of pills that were prescribed to respondent from January 4, 2009, through June 4, 2013, and found that the total was 4,680. The medications included

“hydrocodone 10 mg and acetaminophen 5 mg.” According to Dr. Barnes, this suggested “abusive use of medications.” Dr. Barnes found that “this large number of medications, at maximum dose, [was] suggestive of drug abuse and an addictive nature on the part of [respondent].” Dr. Barnes stated:

What I think is more of a problem and probably should be dealt with by a different specialty is [respondent’s] apparent problem with drug abuse, which has interfered with his life. The large doses over a prolonged period of time of acetaminophen and the medication he has been taking for four years could be very destructive to his liver. I feel his drug abuse problem or addiction is more of a problem than any functional problem as it relates to his shoulders and his hands or other complaints, which he feels do not permit him to carry out his job requirements.

In his October 8, 2013 Supplemental Report, Dr. Barnes concluded that he did not feel that respondent was substantially incapacitated. But Dr. Barnes believed that respondent “would have some difficulty in carrying out all of the functions of his job as it relates to the use of his extremities.”

24. Dr. Barnes’ Hearing Testimony. Dr. Barnes testified that he made no attempt to have respondent squeeze the Jamar dynamometer because, when he asked respondent to squeeze his fingers, respondent did not exert enough pressure. According to Dr. Barnes, it would have been “senseless” for him to ask respondent to squeeze the Jamar dynamometer because he “was sure” that respondent would not squeeze hard enough to move the dynamometer’s needle given his weak squeeze of Dr. Barnes’ fingers. As Dr. Barnes explained, “given [respondent’s] frame of mind,” respondent would not have applied sufficient pressure to squeeze the dynamometer. Dr. Barnes recognized that Dr. Serra asked respondent to squeeze the dynamometer during his independent medical examination in 2009, that respondent exerted less pressure with his right hand than with his left, and that, when an individual is right-handed as respondent is, he will generally exert about 10 percent more pressure with his dominant right hand.

25. Dr. Barnes tried to perform other tests to determine respondent’s use of his fingers, but, again, respondent’s complaints of pain stopped him from fully doing so. For example, when he asked respondent to perform the Phalen’s test by flexing his hands back-to-back, respondent complained that it caused him too much pain. When Dr. Barnes tried to test respondent’s range of motion in his wrists, respondent’s range appeared to be significantly limited due to subjective complaints of pain. But Dr. Barnes found that respondent’s upper extremity reflexes were equal and symmetrical. When Dr. Barnes was trying to determine respondent’s range of motion, respondent denied the ability to rotate his arm behind his back and neck because of severe pain. But respondent had good extension of his elbows and wrists.

26. When examining respondent's range of motion in his lower extremities, Dr. Barnes found that respondent had full range of motion in his hips. Although respondent complained of back pain, Dr. Barnes found no significant complaints of radiating pain, indicating that there was no radiculopathy. Respondent had two operations on his knee. It appeared to Dr. Barnes that the second knee operation was successful. But respondent refused to do the heel-to-toe walk, complaining of pain.

27. With regard to his impressions of respondent set forth in his March 16, 2013 Independent Medical Examination report, Dr. Barnes explained that what he found was that respondent generally had subjective complaints of pain with little objective support. Dr. Barnes used the term "cervical myofascial pain syndrome" to describe respondent's neck pain when he could not find any other objective cause of that pain. He used the term "spondylosis" to describe respondent's arthritis. He used the term "chronic low back pain syndrome" to describe respondent's every day arthritic pain. On direct examination, Dr. Barnes opined that there were no duties of a Program Technician I that respondent could not perform, although he may have "considerable difficulty" while performing them.

28. Dr. Barnes testified that the additional medical records he received after he issued his March 16, 2013 Independent Medical Examination report "fortified" his original opinion that respondent was not substantially incapacitated from performing his usual job duties. Dr. Barnes found that, while respondent had "a lot" of subjective complaints, he appeared to have undergone multiple surgeries when the indications for those surgeries were "somewhat stretched." Dr. Barnes was also "bothered by the fact" that respondent did not get any better after his surgeries, but, instead, got worse. Dr. Barnes pointed out that the functional requirements of respondent's usual duties as a Program Technician I did not require continuous typing. Dr. Barnes also pointed out that when respondent wanted to drive a pool truck in 2010, he was found to have "good grip strength" when examined for a DMV license.

29. In general, Dr. Barnes found that respondent's subjective complaints of pain were not credible based upon the medical records he reviewed. According to Dr. Barnes, respondent's excessive subjective complaints and use of prescription medications were suggestive of drug abuse and an addictive nature.

30. On cross examination, Dr. Barnes could not say whether the surgeries respondent underwent were unnecessary. Dr. Barnes also could not say whether the hand and elbow surgeries respondent had after he was examined by Dr. Serra made respondent's pain better or worse.

31. When asked about his use of the term "considerable difficulty," Dr. Barnes stated that the word "considerable" was a "bad choice," and he would like that word "scratched" from his reports. Dr. Barnes believed that respondent might have "some" difficulty using a keyboard or raising his arms, but he could use the keyboard "intermittently," which was consistent with his job duties since he was not required to

perform “continuous” typing. Dr. Barnes could not say whether the level of difficulty for respondent would increase over the course of an eight-hour day or a 40-hour week.

32. Dr. Barnes believed that respondent’s use of hydrocodone and acetaminophen was “excessive.” Dr. Barnes did not ask respondent and, consequently, did not know whether he was on pain medications at the time he was examined. Dr. Barnes recognized that the number of pain medications respondent was taking could affect his ability to focus at work.

33. Dr. Barnes testified that, in respondent’s “mind,” his subjective complaints of pain may be “sincere,” but Dr. Barnes believed that respondent could carry out his job duties if he put forth his “best efforts.” Dr. Barnes questioned whether respondent had “created” his symptoms in order to obtain disability retirement. He suggested that respondent’s behavior might constitute Munchausen Syndrome, because he had so many surgeries without any success in alleviating his pain.³ But Dr. Barnes conceded that he did not conduct any psychological testing on respondent, and a psychological assessment was beyond his expertise.

Respondent’s Expert Witness

34. DCA called Todd James Winters, M.D., as its expert witness. Dr. Winters graduated from medical school in 1999. He did a residency in internal medicine at U. C. Davis. He is board-certified in internal medicine. For the past 13 years, he has worked at Kaiser Permanente as a primary care physician. He is the Assistant Chief of the Department of Internal Medicine. Since about 2002, he has been respondent’s primary care physician.

35. November 12, 2008 Physician’s Report on Disability. On November 12, 2008, Dr. Winters completed a Physician’s Report on Disability in connection with respondent’s application for disability retirement. In the report, Dr. Winters described his diagnoses and objective findings as:

Rotator cuff impingement on left S/P Mumford SLAP repair

Limited ROM, painful ROM⁴

Cervical spondylosis with degenerative disc disease

³ The MedlinePlus online medical dictionary defines “Munchausen syndrome” as “a psychological disorder characterized by the feigning of the symptoms of a disease or injury in order to undergo diagnostic tests, hospitalization, or medical or surgical treatment.” <<http://www.merriam-webster.com/medlineplus/Munchausen's%20Syndrome>> (as of June 18, 2015.)

⁴ “S/P” stands for status post. “SLAP” is an acronym for “superior labrum anterior to posterior.” “ROM” stands for range of motion.

Limited ROM with bilateral radiculopathy pain. See MRI 10/5/07

Left shoulder treated by outside surgeon so more records outside Kaiser. Recent MRI shoulder shows old injuries (work related) but done after MVA (not work related)⁵

Dr. Winters opined that respondent was substantially incapacitated from performing the usual duties of his job. He described the work activities that respondent was unable to perform as follows:

Unable to sit for more than 1 hour without changing positions or stop using upper extremities due to pain in neck/shoulders

In his November 12, 2008 Physician's Report on Disability, Dr. Winters opined that respondent's incapacity was permanent.

36. May 10, 2009 Visit Verification. On May 10, 2009, Dr. Winters signed a Visit Verification that stated that respondent was "permanently unable to work starting 3/10/09."

37. June 11, 2013 Letter. Dr. Winters wrote a letter dated June 11, 2013, which described respondent's medical diagnoses. Dr. Winters described respondent as "healthy in general except for various orthopedic surgeries and problems" as noted in Dr. Winters' letter. With regard to respondent's shoulders, Dr. Winters wrote:

In 2003 he sustained grade III AC separation after a fall which led to right distal clavicle excision in 2005 by Dr. Shaffer at an outside facility. He also had in 2006 a left shoulder arthroscopic SLAP repair, a rotator cuff tear repair, and a subacromial decompression by Dr. Shaffer. In 2012 he had left arthroscopic subacromial decompression for recurrent pain after MVA.

With regard to respondent's knees, Dr. Winters stated:

ACL reconstruction of the right knee, done in 1985 by Dr. Tipton. After MVA in 2011 he had allograft ACL reconstruction right knee by Dr. Manske with additional finding of tricompartmental osteoarthritis.

⁵ "MVA" stands for motor vehicle accident.

With regard to respondent's neck, Dr. Winters noted: "Cervical joint disc disease seen on xray 2013." With regard to respondent's hands, Dr. Winters noted:

2013 xray showed Degenerative arthritis bilaterally with post operative trapezium changes on right (I do not have records of this prior hand surgery).⁶

Dr. Winters concluded that:

Each one of the areas noted above cause pain predominantly with neck, hand and shoulder movement. I have reviewed his job requirements and his typical office duties such as repetitive use of keyboard, data entry, mousing do aggravate his pain. Because of this I do not feel he is capable of working full duty (8 hour day).

38. May 16, 2015 Letter. Dr. Winters wrote a letter dated May 16, 2015, regarding respondent's medical history and capacity for work. In the letter, Dr. Winters stated that respondent has had "chronic pain for the majority of the time I have been involved in his care." Respondent's "initial source of pain was a right shoulder grade 3 acromioclavicular joint separation after a fall at work in 2003." Respondent had surgery for this condition in 2006. Since then, respondent has had "several surgeries over the years." Dr. Winters listed respondent's surgery as follows:

Excision Clavicle Distal W Reconstruction Ligament 2006

Arthroscopy Shoulder Rotator Cuff Repair 2006

Arthroscopy Shoulder Rotator Cuff Repair 2007

Carpal Tunnel Decompression 2/2011

Carpal Tunnel Decompression 7/2011

Decompression Ulnar Nerve at Elbow 7/2011

Revision Reconstruction of Anterior Cruciate Ligament of Knee
11/29/2011

⁶ Dr. Winters also noted that removal of a mass from respondent's foot in 2013, but at the hearing he clarified that this did not contribute to respondent's incapacity.

Arthroscopic Labral Repair Shoulder 4/6/2012

Excision, Soft Tissue Mass, Foot, Subcutaneous 1/23/2013

Dr. Winters noted that, within the past two years, respondent has been diagnosed with “obstructive sleep apnea, possible fibromyalgia and depression.” Dr. Winters also noted that respondent takes “several medications which can impair cognitive functioning leading to mental slowing, fatigue, and difficulty concentrating.” Physically, respondent has “pain and difficulty with repetitive hand and shoulder movements.” Over time, respondent’s “cumulative pain has increased with each successive procedure and diagnosis.” Dr. Winters opined that, based on respondent’s

... numerous medical and physical diagnoses, the treatment of these diagnoses, review of his job description, and the past 10+ years of providing his primary care, it is my conclusion that he is unable to work. His medical treatment causes a direct inability for him to function mentally as required for a program technician. His physical disabilities prevent him from effectively performing the repetitive nature of his job as a program technician.

39. Dr. Winters’ Testimony. At hearing, Dr. Winters opined that respondent was substantially incapacitated from performing his usual duties as a Program Technician I. Dr. Winters explained that, while respondent’s complaints of pain were subjective, they were consistent with his medical diagnoses. He described respondent’s medical diagnoses for his hands and neck as being arthritis. For respondent’s shoulder, he described respondent’s diagnosis as being related to respondent’s previous surgeries.

40. Dr. Winters reviewed a list of the pain medications respondent has received since 2013. The three main medications respondent was prescribed were: (1) hydrocodone/acetaminophen for pain; (2) Naproxyn, an anti-inflammatory; and (3) Gabapentin for nerve-based pain. Dr. Winters has not seen any evidence that respondent has engaged in addictive behaviors. According to Dr. Winters, the number of pills respondent has taken is consistent with his medical conditions. Dr. Winters opined that the medications prescribed to respondent were medically safe, and provided both functional improvement and pain control.

41. Dr. Winters testified that respondent’s physical impairments were mainly in his neck, shoulders, and hands; that due to these physical impairments, he had baseline pain that he experienced even when he was not moving; and that repetitive activity aggravated his pain. Dr. Winters also opined that respondent’s cognitive functioning has been adversely affected by the medications he is taking.

42. According to Dr. Winters, respondent is unable to sit for more than one hour, but if he were allowed to change positions, stand and stretch, he could sit for eight hours. Dr. Winters believes that respondent is unable to perform three to six hours a day of fine manipulation, keyboarding or mousing, and that he is unable to repetitively use his hands for over six hours in a day. Dr. Winters conceded that respondent may be able to do these tasks for some period of time, but over time, these tasks would “aggravate” respondent’s pain to the point where it would be “very difficult” for respondent to perform his duties. In addition, repetitive use of his shoulders, neck and hands would cause increased stiffness and decreased range of motion, thereby slowing his performance and adversely impacting his job functioning. Dr. Winters opined that, if respondent used his hands repetitively for more than two hours a day, it would aggravate his arthritis to the point where he was non-functional. Dr. Winters did not believe there were any accommodations that could address respondent’s inability to perform repetitive keyboarding.

43. Dr. Winters testified that arthritis generally either gets worse or stays stable; it does not get better. Dr. Winters could not remember whether respondent’s arthritis as shown on his x-rays was mild, moderate or severe. Dr. Winters also could not remember when he last conducted full range-of-motion testing on respondent. He based his opinion as to respondent’s substantial incapacity upon his 10 years of taking care of respondent as a primary care physician. He testified that his opinion took into consideration both respondent’s subjective complaints of pain and the objective evidence of respondent’s orthopedic conditions, including his arthritis. He estimated that about 20 to 30 percent of his opinion that respondent was substantially incapacitated was based upon respondent’s subjective complaints of pain, and that about 70 to 80 percent of his opinion was based upon respondent’s objective diagnoses.

44. Dr. Winters diagnosed respondent with depression based upon respondent’s symptoms. Dr. Winters could not remember whether he had conducted any tests to determine whether respondent’s depression was mild, moderate or severe. He also could not remember whether he had referred respondent to a psychiatrist or a psychologist for treatment of his depression.

45. Dr. Winters described his diagnosis of fibromyalgia as a “work-up in progress.” For the past four months, Dr. Winters has been discussing fibromyalgia with respondent as a “possible diagnosis” given respondent’s diffuse, non-specific pain over large areas of his body.

Respondent’s Testimony

46. Respondent testified about his 10 surgeries. He stated that they were all recommended by physicians. Respondent described the pain in his hands, right thumb, wrists, left elbow, neck, shoulders, and right knee that prevents him from working. He also discussed his migraine headaches and fibromyalgia. He asserted that, when he takes his prescribed pain medication, it slows him down and makes it hard for him to focus.

47. Respondent has not worked regularly since he disability retired in 2009. He volunteers from August to October as an assistant to the football coaches at Christian Brothers High School. As part of his volunteer work, he lines the students up, takes roll call, oversees the students when they fill up the water bucket, and takes injured students to the athletic department. For this volunteer work, respondent receives a stipend. In 2012, his stipend was \$1,400; in 2013, his stipend was \$1,200; in 2014, his stipend was \$1,300. Respondent stated that the stipend was mainly to cover the cost of his gasoline.

48. Respondent blamed the cause of his physical problems on his 2003 fall from his chair at work, which injured his shoulder, and caused a “snowball effect” of pain and surgeries. He asserted that he wanted to return to work so that he could better provide for his family, but was unable to do so because of his pain.

Discussion

49. In 2009, Dr. Serra found that respondent was substantially incapacitated from performing his usual duties as a Program Technician I because he was “unable to utilize a keyboard for several hours due to the arthritis in the carpometacarpal joints of both thumbs and his postsurgical shoulder condition.” Although Dr. Serra found that respondent’s incapacity was “temporary,” CalPERS decided that respondent qualified for disability retirement.

50. In this matter, CalPERS argued that respondent no longer qualified for disability retirement because he was not substantially incapacitated from performing his usual duties as a Program Technician I. CalPERS based its argument solely upon the reports and testimony of Dr. Barnes. CalPERS did not offer a sub rosa video that showed that, since respondent disability retired, he has engaged in activities that were inconsistent with his claims of substantial incapacity. It did not offer evidence that respondent had performed work or participated in sports that might preclude him from receiving disability retirement. It did not offer medical records to show that the arthritis and postsurgical shoulder condition that Dr. Serra identified in 2009 as substantially incapacitating respondent from repetitively utilizing a keyboard have improved or been adequately corrected.

51. In his reports and testimony, Dr. Barnes raised concerns about whether, during the March 15, 2013 examination, respondent was exaggerating his pain or not putting forth his best efforts. These concerns are troubling. But Dr. Barnes did not adequately address or explain in either his reports or testimony how the arthritis and postsurgical shoulder condition identified by Dr. Serra in 2009 had changed or no longer impacted respondent’s keyboard use.

52. In addition, Dr. Barnes offered opinions that undermined his persuasiveness. He raised questions about respondent’s abuse of prescribed medications. If the amount of pills totaled by Dr. Barnes is divided over the number of days in the time period Dr. Barnes identified, it comes to about three pills a day. The testimony of Dr. Winters was persuasive

that the pills that respondent takes were prescribed by his physicians, were appropriate given respondent's pain and diagnoses, and were not indicative of abuse.

Dr. Barnes also raised questions about the number of operations that respondent has undergone, suggesting that respondent might have Munchausen Syndrome. But the evidence presented by Dr. Winters showed that the operations were either deemed appropriate by Kaiser physicians or were approved through respondent's workers' compensation cases. There was insufficient evidence to establish that respondent suffers from a psychological condition that caused him to seek more operations than were medically indicated.

Dr. Barnes was unable to adequately explain what he meant when he stated in his reports that respondent would have "considerable" difficulty performing the usual duties of his job, and how that related to his opinion that respondent was not substantially incapacitated. During cross-examination, Dr. Barnes became frustrated and defensive, and asked that the word "considerable" be "scratched" from his reports. He did not, however, sufficiently explain how the difficulties respondent might have performing the usual duties of his job, particularly the frequent fine manipulation, keyboarding and mousing, and the constant repetitive use of his hands, would affect his capacity to be a Program Technician I.

53. In contrast, Dr. Winters' testimony was direct and persuasive. While disability retirement generally may not be based solely on a member's subjective complaints of pain, Dr. Winters persuasively testified that respondent's pain complaints were only a small part of his opinion that respondent was substantially incapacitated from performing his usual duties. In addition, while a finding of disability retirement must be based on an actual present disability, and not on a fear of potential future injury, Dr. Winters persuasively testified that respondent's current arthritis and constant baseline pain constituted an actual present disability that would be aggravated by repetitive keyboarding to the point where respondent would not be able to perform the usual duties of his job.

54. Because respondent is already receiving disability retirement, the burden was on CalPERS to establish that respondent is no longer substantially and permanently disabled from performing the usual duties of a Program Technician I. CalPERS did not present sufficient evidence to meet its burden of proof. Consequently, its request that respondent be involuntarily reinstated from disability retirement must be denied at this time.

LEGAL CONCLUSIONS

1. In accordance with Government Code section 21192, CalPERS re-evaluates members receiving disability retirement benefits who are under the minimum age for service retirement. That section, in relevant part, provides:

The board ... may require any recipient of a disability retirement allowance under the minimum age for voluntary retirement for service applicable to members of his or her class

to undergo medical examination The examination shall be made by a physician or surgeon, appointed by the board Upon the basis of the examination, the board or the governing body shall determine whether he or she is still incapacitated, physically or mentally, for duty in the state agency ... where he or she was employed and in the position held by him or her when retired for disability, or in a position in the same classification, and for the duties of the position with regard to which he or she has applied for reinstatement from retirement.

2. Government Code section 21193 governs the reinstatement of a recipient of disability retirement who is determined to no longer be substantially incapacitated for duty and, in relevant part, provides:

If the determination pursuant to Section 21192 is that the recipient is not so incapacitated for duty in the position held when retired for disability or in a position in the same classification or in the position with regard to which he or she has applied for reinstatement and his or her employer offers to reinstate that employee, his or her disability retirement allowance shall be canceled immediately, and he or she shall become a member of this system.

3. Government Code section 20026 defines “disability” and “incapacity for performance of duty,” and, in relevant part, provides:

“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.

4. In *Mansperger v. Public Employees’ Retirement System* (1970) 6 Cal.App.3d 873, 876, the court interpreted the term “incapacity for performance of duty” as used in Government Code section 20026 (formerly section 21022) to mean “the *substantial* inability of the applicant to perform his usual duties.” (Italics in original.) In *Hosford v. Board of Administration of the Public Employees’ Retirement System* (1978) 77 Cal.App.3d 854, 862 the court held that a disability or incapacity must currently exist and that a mere fear of possible future injury which might then cause disability or incapacity was insufficient.

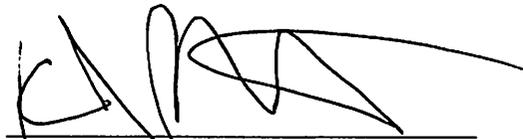
5. To involuntarily reinstate respondent from industrial disability retirement, CalPERS had to establish that respondent is no longer substantially incapacitated from performing the usual duties of a Program Technician I. As set forth in Findings 49 through 54, CalPERS did not offer sufficient evidence at the hearing to meet its burden of proof. Dr. Barnes did not adequately address or explain how respondent’s arthritis and postsurgical shoulder condition identified by Dr. Serra in 2009 had changed or improved such that they

were no longer substantially incapacitating. In addition, Dr. Barnes offered inadequately supported opinions regarding respondent's drug use and psychological condition that undermined his persuasiveness. In contrast, Dr. Winters persuasively testified that respondent's pain complaints were only a small part of his opinion that respondent was substantially incapacitated from performing his usual duties, and that respondent's current arthritis and constant baseline pain constituted an actual present disability that would be aggravated by repetitive keyboarding to the point where respondent would not be able to perform the usual duties of his job. Consequently, CalPERS' request that respondent be involuntarily reinstated from disability retirement must be denied at this time.

ORDER

Respondent's appeal is GRANTED. The request of California Public Employees' Retirement System to involuntarily reinstate respondent Daniel M. Soto from disability retirement is DENIED.

DATED: June 22, 2015



KAREN J. BRANDT
Administrative Law Judge
Office of Administrative Hearings