ATTACHMENT A

THE PROPOSED DECISION

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

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| In the Matter of the Statement of Issues (Application For Industrial Disability Retirement) Of:<br><br>JANET HORN,<br><br>Respondent,<br><br>and<br><br>DEPARTMENT OF DEVELOPMENTAL SERVICES, PORTERVILLE DEVELOPMENTAL CENTER,<br><br>Respondent. | Case No. 2012-0683<br><br>OAH No. 2013041154 |

## PROPOSED DECISION

Karl S. Engeman, Administrative Law Judge, Office of Administrative Hearings, State of California, was assigned to decide this matter based on documents submitted by the parties.

Elizabeth Yelland, Senior Staff Attorney, represented petitioner Anthony Suine, Chief, Benefit Services Division, California Public Employees' Retirement System (CalPERS).

Steven B. Bassoff, Attorney at Law, represented respondent Janet Horn.

Respondent California Department of Developmental[1] Services, Porterville Developmental Services, was not represented.

The parties, in consultation with Presiding Administrative Judge Catherine B. Frink, agreed to a briefing schedule and submission of joint exhibits on or before August 7, 2015.

[1] The Department is misidentified in the caption and elsewhere in the pleadings as the Department of *Development* Services.



CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
FILED 9 Sept 2015

The parties agreed to a submission date of August 7, 2015. Joint exhibits 1 through 17, including trial briefs, were submitted by the parties on August 7, 2015, and the matter was submitted on August 7, 2015.

## ISSUE PRESENTED

Whether respondent Horn was substantially incapacitated for the performance of her usual duties as a psychiatric technician, Department of Developmental Services, Porterville Developmental Center, at the time she applied for an industrial disability retirement.

## FACTUAL FINDINGS

1. Petitioner/complainant Anthony Suine filed the Statement of Issues solely in his official capacity as Chief of the CalPERS Benefits Services Division.

2. Respondent Horn was employed by respondent California Department of Developmental Services, Porterville Developmental Center. At the time respondent Horn filed her application for retirement, she was employed as a psychiatric technician. By virtue of her employment, respondent Horn is a state miscellaneous member of CalPERS subject to Government Code section 21151.

3. On or about March 14, 2011, respondent Horn signed an application for industrial disability retirement. In filing the application, disability was claimed on the basis of injuries to her lower back, right side of her head, elbow and hand.

4. CalPERS obtained medical reports concerning respondent Horn's claimed areas of injury from medical professionals. After review of the reports, CalPERS determined that respondent Horn was not permanently disabled or incapacitated for performance of the usual duties of a psychiatric technician at the time her application for industrial disability retirement was filed.

5. Respondent Horn was notified of CalPERS' determination and was advised of her appeal rights by letter dated February 28, 2012.

6. Respondent Horn filed a timely appeal by letter dated July 19, 2012, and requested a hearing.

*Usual Duties for a Psychiatric Technician Employed by Respondent California Department of Developmental Services, Porterville Developmental Center*

7. A CalPERS' list of Physical Requirements of Position/Occupational Title for Psychiatric Technician at Porterville Developmental Center signed by an employer representative and respondent Horn was received in evidence. A Job Analysis for the same

position prepared by Rehabilitation Counselor Glenda Carberry was also received. Relevant job requirements, based on respondent Horn's claims of incapacity, include standing constantly for over six hours; occasional sitting for up to three hours; frequent walking; frequent bending, twisting, reaching, pushing and pulling, and power grasping. The more specific job analysis requirements include lifting up to 50 pounds alone or 100 pounds with the assistance of another employee when lifting or transferring clients to and from wheelchairs or beds and client restraint. Job specific physical requirements include continuous standing and/or walking while caring for clients; frequent lifting up to 44 pounds and infrequent lifting of up to 50 pounds; frequent torso rotation, bending/stooping, and pushing/pulling; occasional client containment or intervention to protect clients from themselves or harming others; and continuous grasping of equipment.

*Competent Medical Opinion*

*Complainant's Medical Opinion Evidence*

8. Respondent Horn was examined by independent medical examiner Ernest B. Miller, M.D., a board-certified orthopedic surgeon, at the request of CalPERS. Dr. Miller examined respondent Horn on July 23, 2011, and prepared a report the same day that was received in evidence.

9. Dr. Miller's report includes a list of respondent Horn's then-presenting complaints, a history of her injury, Dr. Miller's physical examination of respondent Horn, a review of pertinent medical records, Dr. Miller's diagnoses, and Dr. Miller's summary and conclusions regarding respondent Horn's claimed disability.

10. Respondent Horn was 48-years-old when she was evaluated by Dr. Miller. Her then-current complaints listed in order of importance were sharp, constant lower back pain radiating into her buttocks and both thighs to her knees and groin; loss of balance; numbness and tingling in her feet and toes; and headaches from the top of her head to her neck.

11. Respondent Horn described the history of her injury to Dr. Miller. It began on January 23, 2009, when a client pushed respondent Horn approximately 14 feet across a room where respondent Horn collided with a steel door frame striking the right side of her head, her right elbow, the right side of her lower back and her right hand. Dr. Mathews treated respondent Horn for what he diagnosed as a concussion and contusions. In April of 2009, respondent Horn was evaluated by Dr. Durazo whose diagnoses were concussion, whiplash and spondylosis. According to respondent Horn, Dr. Durazo referred her to five specialists, but her symptoms were unresolved. Dr. Durazo pronounced her permanent and stationary for worker's compensation purposes on March 16, 2011. Respondent Horn said that she had not returned to work since January 23, 2009.

12. Dr. Miller performed a physical examination of respondent Horn's areas of complaint. He noted that respondent Horn walked with a remarkably awkward gait and used

a cane held in her left hand. Her range of motion of her lumbosacral spine was zero percent of normal as respondent Horn made no attempt to demonstrate range of motion of her lumbar spine. Reflexes and pulses were normal. Her straight leg raising test was negative at 90 degrees in the sitting position. Left and right thigh and calf circumferences were identical.

13. Dr. Miller chronicled the treatment of respondent Horn's condition as reflected in the medical records he reviewed. Respondent Horn was seen in the emergency room for her injury on January 23, 2009. X-rays revealed no fractures and the diagnoses were scalp contusion, acute cervical strain, and right hip contusion. Dr. Mathews, an occupational medicine specialist, began treating respondent Horn on January 26, 2009. He diagnosed her as having suffered a mild cerebral concussion, cervical strain, left trapezius muscle strain, low back contusion, right hand contusion, and resolved right elbow contusion. He placed her off duty and prescribed Tylenol, Vicodin and Flexeril. Dr. Mathews saw respondent Horn thereafter on six occasions from February 6, 2009, until March 5, 2009. When he referred respondent Horn to Dr. Durazo, another occupational medicine physician, on March 5, 2009, Dr. Mathews noted that respondent Horn complained of intermittent mild headaches in the back of her head, occasional low back pain, and that she no longer used a cane. Dr. Mathews continued prescriptions for Celebrex and Ultram and continued her off-duty status.

14. Dr. Durazo first saw respondent Horn on March 10, 2009. His diagnoses were concussion syndrome, migraine headaches exacerbated since injury, and persistent low back strain. He prescribed Elavil and Imitrex and a modified work assignment precluding repetitive bending, twisting, and lifting more than 20 pounds. Dr. Durazo saw respondent Horn at least 25 times between March 10, 2009 and February 16, 2011. During that time, respondent Horn also attended physical therapy sessions. Dr. Durazo ordered a lumbar MRI which was performed on May 26, 2009. The physician reading the MRI results reported degenerative changes at the L4-5 interspace including spondylolisthesis and effacement of the adjacent anterior thecal sac greater to the right and moderate to advanced central stenosis. Dr. Durazo requested a neurological consultation after the MRI results. The neurosurgeon who reviewed the MRI scan recommended an exercise focused physical therapy program and remarked that respondent Horn would also benefit from lumbar epidural steroid and facet injections. If these did not result in improvement, she would need a lumbar laminectomy at L4-5. Respondent Horn completed nine additional physical therapy sessions.

15. Dr. Hoyt, the neurosurgeon, also asked for lumbar x-rays which were taken on September 15, 2009. Dr. Hoyt read the x-rays and repeated his recommendation of epidural steroid and facet injections.

16. On February 19, 2010, a different neurosurgeon saw respondent Horn and ordered nerve conduction studies. An EMG and NCS were taken on March 29, 2010. The physician who read the results reported that the EMG of the musculature of both lower extremities and paravertebral lumbar interspaces were normal. There was no evidence of either acute or chronic lumbar radiculopathy. The nerve conduction study of the peroneal nerves, bilaterally, was normal. F-wave latency peroneal nerve bilaterally was normal. H-

wave latency tibial nerves bilaterally were normal and symmetrical. Respondent Horn made it clear that in the absence of nerve damage, she did not want low back surgery.

17. Respondent Horn saw a pain management specialist physician on August 5, 2010. The doctor's diagnoses were chronic low back pain secondary to lumbar degenerative disc disease with bilateral radiculopathy at L4-5; bilateral lumbar facet joint arthropathy at L5-S1 and bilateral sacroiliac joint arthropathy, right more than left; and positional problems related to her severe pain. Lumbar epidural steroid injections were once again recommended. Respondent Horn received the first lumbar epidural injection on October 26, 2010. She reported marked relief to Dr. Durazo in a visit on November 10, 2010. She reported continued relief in her visit to Dr. Durazo on December 8, 2010. She had a second injection on February 8, 2011, and one week later reported to Dr. Durazo that she experienced immediate pain following the injection that she described as "wrapped around into her groin."

18. Dr. Miller's diagnoses of respondent Horn's conditions were multiple contusions of the head, neck, upper extremities, lower extremities, lower back, and buttock; and residual symptoms and complaints that exceed laboratory studies and physical examination. He observed that respondent Horn presented with multiple problems that were not indicative of any significant musculoskeletal problem. He recommended a psychological evaluation. Dr. Miller concluded that respondent Horn does not require any work restrictions based on her musculoskeletal injury as there is no disability.

*Respondent's Medical Opinion Evidence*

19. Among respondent Horn's medical evidence are four reports authored by Richard Byrne, M.D., a board-certified orthopedic surgeon. All of the reports address respondent Horn's worker's compensation claim for the same injury. In the first Qualified Medical Evaluation prepared by Dr. Byrne on February 6, 2010, he discussed his examination of respondent Horn on January 29, 2010. Respondent Horn told Dr. Byrne that she had worked as a psychiatric technician for approximately eight and one half years before she was shoved by a patient and suffered her injuries on January 23, 2009. She denied any previous back pain. After treatment began with Dr. Mathews, she was allowed to return to work on March 17, 2009, with work restrictions. She ceased work on May 11, 2009, when she could no longer be accommodated. Dr. Byrne interpreted the MRI results as demonstrating what he characterized as "significant advanced central spinal stenosis" at L4-5. Respondent Horn was taking four Vicodin per day in addition to Ibuprofen and Skelaxin. She was seeing Dr. Durazo on a monthly basis. Respondent Horn complained of significant pain in her low back with lesser pain in her buttocks and legs. She experienced tingling in her toes. She had intermittent pain down the back of her legs throughout the day. She used a cane all of the time. She described the pain as a 5 on a 10 point scale. She stated that she could not sit, stand, or walk for more than 30 minutes. She had difficulty sleeping.

20. Dr. Byrne reviewed the job description for a psychiatric technician. He noted that continuous standing and walking are required as are torso rotation, bending, stooping,

and pushing and pulling. Dr. Byrne performed a physical examination of respondent Horn. He described her as uncomfortable and quite histrionic during the examination. She changed positions frequently. Dr. Byrne attempted to examine her lumbar spine. Flexion was 15 degrees, extension was 5 degrees, and lateral bending was 20 degrees on both sides. Rotation was equal but abnormal on both right and left. Respondent Horn stood on her toes, but not her heels. She did not squat. Straight leg raising was positive in the sitting position with low back pain bilaterally. In the supine position, low back pain began at 20 to 30 degrees bilaterally. There was marked right lower lumbar tenderness and questionable facet tenderness bilaterally.

21. Dr. Byrne's diagnostic impressions were (1) contusion and sprain/strain of the lumbar spine as a result the injury; and (2) pre-existing L4-5 spondylolisthesis with facet hypertrophy and central spinal stenosis. In his discussion, Dr. Byrne commented that respondent Horn's cervical spine had improved and her arm and hand were no longer symptomatic. She persisted in having significant low back pain with positive straight leg raising bilaterally. He stated: "She is rather hysterical with the amount of discomfort that she seems to experience." She was not, in his opinion, then capable of performing her usual and customary duties even with restrictions.

22. Dr. Byrne re-examined respondent Horn on November 5, 2010, and his Qualified Medical Reevaluation is dated November 13, 2010. Dr. Byrne noted that since the first visit, respondent Horn had undergone electrodiagnostic studies on March 29, 2010, and that the EMG and nerve conduction studies of the bilateral lower extremities and paravertebral lumbar interspaces were normal. There was no evidence of acute or chronic lumbar radiculopathy. Respondent Horn had undergone the first of the epidural blocks one week before this reevaluation. She reported less pain and a greater ability to get up and about. She continued to limp and use a cane. She continued to take Vicodin four times per day, along with Skelaxin and Ibuprofen for pain. She complained of low back pain and referable pain in the back of her skull just above the cervical spine. She experienced lesser pain in her buttocks and posterior thighs bilaterally. She reported muscle spasms up and down her back at times. She felt tingling and numbness in her toes. Respondent Horn reported that her entire back was stiff and she ached all over.

23. Dr. Byrne's physical examination on this occasion included another range of motion study of respondent Horn's lumbar spine. He reported that, "The examination was performed with difficulty. She tended to be quite histrionic when performing her attempted range of motion modalities." Lumbar flexion was 25 degrees, extension was 15 degrees, and rotation was about 50 percent of normal. She stood on her toes and heels but refused to squat. Straight leg raising was negative in the sitting position, but positive in the supine position bilaterally at about 30 degrees with low back pain. There was tenderness right and left at L5-S1, and L4-5. Dr. Byrne's diagnostic impressions on this occasion were (1) contusion/sprain/strain of the lumbar spine as result of January 23, 2009 injury; (2) L4-5 spondylolisthesis with central spine stenosis and facet hypertrophy, preexisting; and (3) possible anxiety and depressive disorder. In the "Discussion" portion of the evaluation, Dr. Byrne recommended two more steroid injections. He characterized respondent Horn as a

poor candidate for surgery because of her questionable emotional stability. In his view, she was not yet permanent and stationary, but remained totally disabled. She could not perform any meaningful work activity in his estimation.

24. Dr. Byrne's next Qualified Medical Reevaluation took place on August 19, 2011, and his August 23, 2011 report was received in evidence. Dr. Byrne noted the unsuccessful second steroid injection which worsened respondent Horn's pain. Respondent Horn complained of pain in her entire pelvic area since the second injection and expressed her disinterest in any further injections or back surgery. Her right elbow was asymptomatic, but she was otherwise just as uncomfortable and unable to do virtually anything as in the past. She continued to take Vicodin four times a day along with Skelaxin and Ibuprofen. She also complained of headaches at the base of her skull, pain on occasion down her upper right extremity, constant pain in her lower back, muscle spasms in her buttocks and calves, numbness in her right hand and arm, and tingling at times in her legs. Respondent Horn continued to use a cane at all times.

25. Dr. Byrne listed as the objective factors of disability for respondent Horn the lumbar spine MRI revealing L4-5 spondylolisthesis with significant advanced central spinal stenosis associated with facet arthropathy, her constant use of a cane, the impossibility of performing a spine range of motion examination, normal neurological examination, positive straight leg raising in both the sitting and supine positions, lumbar, sacroiliac, and sciatic notch tenderness primarily on the right, and tenderness at the base of her skull. Under his heading "Subjective Factors of Disability," Dr. Byrne stated: "It is my opinion that Ms. Horn experiences frequent to constant slight low back pain with radiation into her bilateral lower extremities and occasional moderate pain in her low back which is a result of activity." Dr. Byrne also listed as subjective factors respondent Horn's statements that she must use a cane, she experiences tingling in her bilateral lower extremities, and she has significant ADL restrictions. Dr. Byrne opined that the spinal stenosis and spondylolisthesis were the probable impediments to respondent Horn's recovery from her injury within six to twelve weeks. He felt that she would eventually agree to a laminectomy and fusion at L4-5. Dr. Byrne stated that respondent Horn could only perform semi-sedentary work with the assistance of a cane and these restrictions would preclude her from returning to her usual and customary duties as a psychiatric technician for Porterville Developmental Center.

26. Dr. Byrne authored a Supplemental Report dated October 9, 2011, in which he fixed the date that respondent Horn was permanent and stationary as June 13, 2011. This was based on that assessment by her treating physician Dr. Durazo who had seen respondent Horn every three months.

*Psychological Evaluations Submitted by Respondent Horn*

27. Respondent Horn included among her exhibits two Agreed Medical Evaluations-Psychological authored by Robert Len Richardson, Ph.D., a board-certified clinical psychologist. The reports, dated October 27, 2013, and April 21, 2015, respectively, were addressed to the parties to worker's compensation claims based on respondent Horn's

injury on January 23, 2009, and an unresolved earlier claim based on injuries to respondent Horn's left hand at respondent Porterville Developmental Center occurring on November 23, 2002. Respondent Horn's counsel in this matter, in his written brief, relied in part upon the psychological reports in support of his contention that his client is substantially incapacitated for her usual duties as a psychiatric technician. CalPERS's counsel, while noting that respondent Horn did not assert any psychological incapacity in her application and has not been evaluated by CalPERS for such disability, nonetheless answered the claim for psychological disability in her brief. In substance, CalPERS contends that as Dr. Richardson is not a medical doctor, his reports do not meet the "competent medical opinion" standard in Government Code section 20026 quoted in part below. CalPERS also argues that neither report addresses the issue to be resolved, i.e., whether respondent Horn is substantially incapacitated for the performance of her usual duties.

28. As noted in Factual Finding 3, respondent Horn filed an application for industrial disability retirement based on the orthopedic conditions she listed in the application. Based on those claims, CalPERS requested the orthopedic evaluation performed by Dr. Miller. His report, and those of orthopedic surgeon Dr. Byrne, are clearly germane to the issue presented by respondent Horn's application. In contrast, the two evaluations by Dr. Richardson do not address the issue of the alleged orthopedic disability and are therefore not relevant to that issue. If a mental injury claim were added, CalPERS administrators would presumably be required to evaluate the reports and, if they felt it necessary, seek an independent medical examination by a psychiatrist or other qualified specialist. Consequently, the reports of Dr. Richardson are not considered in resolving the issue of whether respondent Horn is substantially disabled for the performance of her duties as a psychiatric technician.

*Resolution of Conflicts in the Medical Opinion Evidence*

29. The disagreements between Dr. Miller and Dr. Byrne regarding respondent Horn's disability, or lack thereof, begin with their respective interpretation of the MRI results of May 26, 2009 and the x-rays taken on September 3, 2009. As noted above, the physician reading the MRI reported "Degenerative changes at the L4-5 interspace including spondylolisthesis (vertebra slid sideways out of alignment with adjacent vertebra) and effacement of the adjacent anterior thecal sac (slight protrusion into the material surrounding the spinal cord) greater to the right. There is also moderate to advanced central stenosis (narrowing of the spinal canal)."[2] The physician reading the x-rays reported: "Grade 1 spondylolisthesis of L4 on L5 exacerbated in the flexion view. Mild degenerative joint disease. Narrowing of the L4-5 disc space from a degenerated disc." Dr. Miller characterized the MRI findings as "normal with some age appropriate degenerative disc disease, primarily involving L4-5." Dr. Byrne attributes respondent Horn's persistent low back and related problems to the stenosis and spondylolisthesis. This suggests however, that the lumbar spine conditions are causing nerve compression symptoms of the types that

[2] Parenthetical explanations added by Administrative Law Judge.

respondent Horn reports. That premise seems to be negated by the EMG and NCS studies performed on March 29, 2010, that found no evidence of acute or chronic lumbar radiculopathy and that nerve conduction, both motor and sensory, were normal bilaterally.

30. Moreover, even Dr. Byrne's interpretation of the diagnostic studies does not explain the seemingly exaggerated symptoms reported to both evaluators by respondent Horn. Respondent Horn did not even try to perform the standard range of motion tests of her lumbar spine when she saw Dr. Miller. She did little better when she was evaluated by Dr. Byrne, with flexion to only 15 degrees and extension to only 5 degrees. In his August 23, 2011 reevaluation report, Dr. Byrne commented that the range of motion method is the preferred method for determining respondent Horn's impairment, but it was not used because of his inability to adequately examine her due to her pain syndrome. In summary, respondent Horn's reported symptoms and claimed disability were unsupported by the objective evidence relating to her condition as noted by Dr. Miller.

31. Dr. Miller's evaluation was the more persuasive assessment of respondent Horn's condition. This includes his conclusion that respondent Horn is not substantially incapacitated by reason of any orthopedic condition for the performance of her usual duties as psychiatric technician at Porterville Developmental Center.

## LEGAL CONCLUSIONS

1. An applicant for retirement benefits has the burden of proof to establish a right to the entitlement absent a statutory provision to the contrary. (*Greatorex v. Board of Administration* (1979) 91 Cal.App.3d 57.) The party asserting the affirmative at an administrative hearing has the burden of proof including both the initial burden of going forward and the burden of persuasion by a preponderance of the evidence. (*McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051 fn.5, citing *So. Cal. Jockey Club v Cal. etc. Racing Bd.* (1950) 36 Cal.2d 167, 177.)

2. Government Code section 20026 reads, in pertinent part:

> '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 performance of duty means the substantial inability to perform usual duties. (*Mansperger v Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876.) In *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, at page 860, the court rejected contentions that usual duties are to be decided exclusively by State Personnel

Board job descriptions or a written description of typical physical demands. The proper standard is the actual demands of the job. (See also, *Thelander v. City of El Monte* (1983) 147 Cal.App.3d 736.) The ability to substantially perform the usual job duties, though painful or difficult, does not constitute permanent incapacity. (*Hosford, supra*, 77 Cal.App.3d 854, at p. 862.)

4. Respondent Horn had the burden of producing evidence to support her application for industrial disability retirement, including the burden to produce "competent medical opinion" that her physical condition rendered her substantially incapacitated for the performance of her usual duties. Respondent Horn did not sustain her burden. Moreover, CalPERS presented competent medical opinion evidence establishing that respondent Horn is not substantially incapacitated for the performance of her usual duties as a psychiatric technician by reason of her claimed orthopedic injuries. Therefore, respondent Horn's application must be denied.

## ORDER

Respondent Horn's appeal from CalPERS' determination that she was not permanently disabled or incapacitated for the performance of her usual duties as a psychiatric technician with respondent California Department of Developmental Services, Porterville Developmental Center, at the time that her application for disability was filed is DENIED.

Dated: September 2, 2015

KARL S. ENGEMAN
Administrative Law Judge
Office of Administrative Hearings