

ATTACHMENT A
THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

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

MONTELL D. PIERCE,

Respondent,

and

CALIFORNIA STATE PRISON - LOS
ANGELES COUNTY, CALIFORNIA
DEPARTMENT OF CORRECTIONS AND
REHABILITATION,

Respondent.

Case No. 2014-09c9

OAH No. 2015010237

PROPOSED DECISION

Administrative Law Judge Ralph B. Dash heard this matter on September 16, 2015, in Los Angeles, California.

Rory J. Coffey, Senior Staff Counsel, represented the California Public Employees' Retirement System (CalPERS).

Montell D. Pierce (Respondent) represented himself.

California Department of Corrections and Rehabilitation (CDCR) did not appear.¹

SUMMARY

Respondent's application for industrial disability retirement based on an orthopedic condition (right knee, lower back, left wrist) was approved by CalPERS on May 14, 2011,

¹ CDCR was duly served with the Accusation and Notice of Hearing. The matter proceeded as a default against this respondent pursuant to Government Code section 11520, subdivision (a).

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM
FILED Sept. 29, 2015
C. Bodily

and he was retired for disability effective as of October 6, 2010. CalPERS subsequently conducted a review of Respondent's medical condition. The sole issue is whether Respondent is currently substantially unable to perform his usual duties as a Correctional Supervising Cook because of an orthopedic condition. CalPERS concedes that it bears the burden of proving that Respondent is not currently disabled. As discussed below, CalPERS did not meet its burden, and its determination that Respondent is not currently disabled is not supported by the evidence.

FACTUAL FINDINGS

1. Respondent was employed by CDCR as a Correctional Supervising Cook. On February 18, 2011, he submitted an application to CalPERS for industrial disability retirement based upon an orthopedic condition including his right knee, his lower back and his left wrist.² CalPERS approved the application on May 14, 2011, and Respondent retired for disability effective as of October 6, 2010.

2. On December 30, 2013, CalPERS notified Respondent that it conducts reexaminations of persons on disability retirement and his file was currently under review (Exhibit 7).

3. On July 23, 2014, CalPERS notified Respondent that he was no longer eligible for disability retirement benefits and that he should work with his employer to be reinstated as a Correctional Supervising Cook.³

4. On July 29, 2014, Respondent wrote to CalPERS appealing its decision that he was no longer substantially incapacitated for performing the job duties as a Correctional Supervising Cook. This hearing ensued.

Testimony of Clive M. Segil, M.D.

5. CalPERS referred Respondent to Clive M. Segil, M.D. for an independent medical examination (IME). Dr. Segil is a Diplomate of the American Board of Orthopaedic Surgery. He is a Fellow of both the American College of Surgeons and the Royal College of Surgeons. He is also a Qualified Medical Examiner.

6. Included with CalPERS' referral of Respondent to Dr. Segil were some of Respondent's medical records, which Dr. Segil summarized (Exhibit 13) as part of his report (Exhibit 10). Although Dr. Segil very briefly mentioned the records summary in his

² In its Accusation (part of Exhibit 1), CalPERS referenced only Respondent's knee.

³ This letter was not offered in evidence. However, it was referenced in Exhibit 8.

testimony and his report, the contents of those records is essential to this proceeding. In relevant part, the 13-page, single spaced records review, shows the following:

7/14/2008 Greg R. Sobeck, M.D. — Los Angeles Orthopedic Institute

Date of injury 07/04/2008 History of Present Complaint The patient is a 42-year-old correctional supervising cook who has worked for the California State Prison in Lancaster for approximately two years. He indicates that on 04/04/2008, he was working around the ovens in the kitchen at work when he slipped and fell. He landed on his right knee, but in falling, he attempted to break his fall with an out stretched left upper extremity, causing injury not only to his right knee, but also to his left upper extremity and wrist. He reported this injury immediately and he was evaluated at High Desert Occupational Medical Group, the same date as the fall. He was initially treated with Dr. Nathaniel Bautista and Dr. Tommy Leong but subsequently was referred to Dr. Jon Kayvanfar who performed arthroscopic right knee surgery on 06/12/2008. At this time, the patient is approximately one month status post right knee arthroscopy and is recovering nicely from his right knee arthroscopy. He also indicates that he was diagnosed with a scaphoid fracture in the left wrist, which was treated in a cast, but he indicates that the cast was subsequently removed and was told that scaphoid fracture was healed. Overall Diagnostic Impression. Industrial injury on 04/04/2008 Right knee injury secondary to industrial injury, 04/04/2008, status post arthroscopy, 06/12/2008 (operative report not available at this time). Left wrist sprain/strain with presumed navicular fracture. Discussions of Causation-The mechanism of the injury as related to him and by the patient does appear consistent with his injuries, and he finds no basis upon which to question or deny injury AOE/COE in this case. Disability Status-At this time, the patient has not reached maximum medical improvement as he just had surgery on his right knee one month ago He is in need of additional treatment in the form of recovery for right knee and left wrist injuries, and he should be allowed to continue treating with his treating physician Dr. Kayvanfar.

Dr. Sobeck felt that he would reach maximum medical improvement within six months following his knee surgery. Work Status-At this time, the patient is not working. Dr. Sobeck believes he should remain off work unless work is available that he can perform primarily in a seated fashion, and with avoidance of frequent or repetitive use of the left upper extremity if this is not possible, he should remain off work on temporary total disability while he continues to recover from his injury and subsequent surgery

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01/17/2009 — John Kayvanfar MD --

Date of Injury February 4, 2008 History of Injury Unchanged Diagnoses -- Right and left knee sprain Early carpal tunnel syndrome. Torn medial meniscus of the right knee. Treatment/Recommendations--Medications nonsteroidal anti-inflammatory, analgesics, muscle relaxer. Authorization for surgery was obtained and surgery was performed on 06/12/2008. On 12/12/2008, the patient has reached maximum medical improvement with respect to the knee and left wrist. Work Restrictions-- Return to the original occupation on 10/23/2008--Duration of Disability: The patient was temporarily totally disabled until 10/22/2008. Disability with respect of right knee--No repeated squatting, twisting, climbing, walking long distance on uneven plains/terrains--Work Restrictions No lifting over 25 pounds Future Diagnostic Test Would be in terms of x-rays, blood test per FDA requirement to black label of medications Future Medical/Surgical Treatment The patient needs to have access to doctor of his choice to receive his medication and on as needed basis. . . . Total Impairment for Right Knee . . .

04/17/2009 — Greg R Sobeck MD — Los Angeles Orthopaedic Institute
History of Injury Unchanged

Date of Injury April 4, 2008 Overall Diagnostic Impression History of industrial injury involving the low back and the lower extremity on April 4, 2008 Right knee medial meniscal tear and chondromalacia. . . . He also had a prior industrial injury involving his back and both lower extremities from February 5, 2001. Disability Status--The patient has reached a permanent and stationary status upon being declared so by his primary treating physician, Dr Kayvanfar, on December 12, 2008. The patient is working at his regular job as a cook at the California State Prison in Lancaster. He has pain on a daily basis, but this does not interfere with his work. **He should have a permanent prophylactic restriction against constant standing and walking.** He should be able to sit while working or on a break, for at least five minutes out of every hour. . . . Future medical care is indicated With respect to the right knee is appropriate, MRI of the right knee, oral anti-inflammatory medications, and no narcotic analgesics. Additional surgery may possibly be necessary based upon the results of the MRI examination. (Emphasis added.)

[¶] . . . [¶]

10/19/2009 —

Dr Sobeck believes that if modified duty were available to him, he could work, however, this does not appear to be the case. **Modified work for the patient would consist of restrictions against constant standing and walking and he would need to have frequent sitting breaks.** (Emphasis added.)

[¶] . . . [¶]

02/22/2010 — Jalil Rashti, MD — Temple Community Hospital Operative Summary — Preoperative Diagnosis--Medial meniscal tear, right knee. Postoperative Diagnoses Chondromalacia grade III medial femoral condyle; Chondromalacia grade IV femoral groove Synovial thickening. Operation Performed: Arthroscopy right knee Chondroplasty

[¶] . . . [¶]

03/16/2012 Jalil Rashti M.D. Center for Orthopedic & Rehabilitation-- Primary Treating Physician's Final Report of Occupational Injury

Date of Injury 04/04/2008 History of Injury-Unchanged. Diagnoses: Status post right knee arthroscopy 02/22/2010. Left carpal tunnel syndrome Sleep disturbance with memory loss and trouble with daytime concentration. Psychiatry issues, this (*sic*) addressed by an appropriate specialist (psychiatry or psychology). Permanent and Stationary-The patient is considered to be permanent and stationary at this point in time. . . . **Work Restrictions: For the knee, right knee restrictions--No climbing, walking over uneven ground, squatting, kneeling, crouching, crawling, pivoting or other comparable physical effort.** For left wrist and hand restrictions: Limited repetitive forceful gripping and grasping with the left wrist and hand. **Future Medical Care--In regard to the right knee: Orthopedic consultations, re-evaluations and diagnostic studies. Conservative therapy is indicated as needed and may include 12 visits per year, including transcutaneous electrical nerve stimulation for, pain control, ultrasound to reduce inflammation and promote healing, physio-rehabilitation and stretching to increase flexibility, hydro to soften tissue and promote circulation, myofascial release to reduce adhesions, referral for MRI, and medications such as anti-inflammatory, analgesics and injectable corticosteroids. The patient will require the use of a home exercise program on a regular basis. Surgery specific for follow-up arthroscopic hospital and postoperative rehabilitative care.** In regard to the left wrist and hand--Future care may include, but should not be limited to, orthopedic and hand specialist consultations, re-evaluations and diagnostic studies. This is considered necessary to evaluate the progressive nature of the patient's disability and monitor complications thereafter. Conservative therapy is indicated as needed and may include 12 visits per year, including physio-rehabilitation, stretching to increase flexibility, myofascial release to reduce adhesions, phonophoresis to reduce inflammation and promote healing, paraffin to soften tissue and promote circulation, referral for EMG/NCV, and medications such as anti-inflammatory, analgesics and injectable corticosteroids. Surgery is specific to the left carpal tunnel release, and appropriate hospital and postoperative rehabilitative care **The patient has reached maximum medical**

improvement and is considered permanent and stationary. (Emphasis added.)

7. On June 13, 2014, Dr. Segil conducted an IME of Respondent. He explained at the hearing that he begins his IME's by having the patient describe his present complaints, and he then performs a physical examination. He stated that he does not do the review of records until after he has completed the physical exam so that his opinion would not be affected by the conclusions reached by the treating physicians.

8. In his report, Dr. Segil noted Respondent's "chief complaints" as "pain in the right knee" and "pain in the low back." He noted that Respondent's wrist pain had "resolved." His report indicates that Respondent "has only a small ache in the lower back with some radiation of pain into his right leg all the way to his toes. It is a constant pain, aggravated by nothing in particular and relieved by pain medications." He further notes that with respect to his right knee, Respondent "has pain all over the front of the knee. It is a constant quite severe pain aggravated by use, movement, walking and standing and relieved by analgesic medication."

9. Dr. Segil stated that he agreed with the treating doctors' conclusions of their evaluations of Respondent. However, he never explained how Respondent, who his treating physicians said was disabled for the performance of his usual and customary duties as a Correctional Supervising Cook had somehow managed to recover from the disabilities which had reached "maximum medical improvement" in March 2012.

10. Dr. Segil spent no more than 30 minutes with Respondent, and he ordered knee X-rays. He did not order an MRI. Dr. Segil stated that the exam and X-rays were sufficient for him to make his determination regarding Respondent's ability to perform the usual and customary duties of a Correctional Supervising Cook. However, neither in his testimony nor in his report did Dr. Segil ever analyze what those duties actually entailed. All he stated in his report was that he had reviewed "four pages" (presumably the job description found in Exhibit 15) of essential job duties and qualifications for Respondent's former position as a Correctional Supervising Cook.

11. Dr. Segil did not dispute that, as of the date of the IME, Respondent had "constant quite severe pain aggravated by use, movement, walking and standing." However, he did not explain how Respondent was supposed to perform his usual and customary duties when his job required that for up to two-thirds of an average work day, Respondent's duties involved standing and walking. He did not dispute that Respondent could not lift up to 50 pounds nor push a 1500 pound food-laden cart, even though those duties are specified in the job description. Respondent's un rebutted testimony was that he could not perform those tasks. He also testified that he would often be called upon to lift 50-pound food trays when the inmates had to be fed in their cells "during lockdown." He estimated this occurred on average twice per week.

12. Respondent testified that he currently has a light duty job as a janitor. He can take rest breaks at any time. He is able to do more physically demanding work if he takes pain killers, such as oxycodone. He took oxycodone before his IME. Dr. Segil testified that Respondent's ability to do a squat showed his back and knee injuries did not preclude him from performing his duties as a Correctional Supervising Cook. However, the issue is not whether Respondent could physically do a squat. The issue, which Dr. Segil failed to address, is whether Respondent could do so if he were not medicated.

13. Respondent offered several medical documents. One document, part of Exhibit C, is an MRI report, dated September 21, 2011, of Respondent's right knee, which shows "several articular cartilage fissures" involving the articular surface of the patella and the corresponding anterior femur. The significance of these fissures is that with them, the knee cartilage is susceptible to injury.⁴ This MRI also shows that in 2011, Respondent's right knee had an "oblique tear of the body of the medial meniscus extending to the inferior articular surface."

14. Respondent's knee has not healed on its own. As noted towards the end of the medical report review in Finding 8, the possibility of additional knee surgery was left open as an alternative treatment. A much more recent MRI shows that Respondent's knee has continued to deteriorate. An MRI of Respondent's right knee done on September 3, 2015, (Exhibit A) shows a "horizontal tear at the junction between the body and anterior horn of the lateral meniscus, extending laterally as well as to the superior articular surface." While Dr. Segil felt this tear was not of clinical significance with respect to Respondent's performance of his usual and customary duties, he did not explain the basis for his opinion, nor did he touch upon the issue of the apparent continued deterioration of Respondent's knee.

15. Dr. Segil did not discuss Respondent's continuing back pain. Respondent is currently treating for back pain with Lancaster Pain Management where he has been diagnosed with, among other things, lumbar radiculopathy. (Exhibit A.) In his report, Dr. Segil noted that Respondent has "radiation of pain into his right leg all the way to his toes" which is, in essence, the same finding as Lancaster Pain Management.

16. As discussed in Legal Conclusion I, the decision that Respondent is physically incapacitated for the performance of his usual duties as a Correctional Supervising Cook, and therefore eligible to retire for disability, must be based on competent medical evidence. The competent medical evidence in this matter consists of Dr. Segil's IME report and testimony, his records review, and the additional medical records offered by Respondent. CalPERS concedes that it has the burden of proving by a preponderance of the evidence that Respondent is no longer physically incapacitated for the performance of his usual duties.

⁴ This particular statement was presented to the Administrative Law Judge in un rebutted medical testimony in another matter, and is cited here under the provisions of Government Code section 11425.50, subdivision (c).

17. Dr. Segil did not discuss, either in his report, or during his testimony, the contents of the medical records he reviewed other than to state that he found no fault with the conclusions reached by Respondent's treating physicians. And while he said he reviewed the job description of a Correctional Supervising Cook, he did not discuss or explain his understanding of Respondent's usual duties. It is Respondent's "usual duties" as a Correctional Supervising Cook that are relevant. (See *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, 860-861 ["In determining eligibility for disability retirement, the applicant's actual and usual duties must be the criteria against which any impairment is judged, and generalized job descriptions and physical standards are not controlling"].)

18. Dr. Segil's opinion that Respondent is not physically incapacitated for the performance of his usual duties as a Correctional Supervising Cook for CDCR is not persuasive. He did not explain the extent of his knowledge of Respondent's actual duties as a Correctional Supervising Cook, so there is no way to assess the persuasiveness of his opinion that Respondent is not incapacitated from performing those duties. (See, *Jennings v. Palomar Pomerado Health Systems* (2004) 114 Cal.App.4th 1108, 1117 ["Similarly, when an expert's opinion is purely conclusory because unaccompanied by a reasoned explanation connecting the factual predicates to the ultimate conclusion, that opinion has no evidentiary value because an 'expert opinion is worth no more than the reasons upon which it rests.' (Citation.)"]) Therefore, CalPERS has failed to meet its burden of establishing that Respondent is not physically incapacitated for performing the usual duties of a Correctional Supervising Cook and Respondent's appeal from CalPERS' determination that he be reinstated to his former position as a Correctional Supervising Cook with the CDCR should be granted.

LEGAL CONCLUSIONS

Applicable Law

1. Any safety member employed by the State of California who becomes "incapacitated for the performance of duty as a result of an industrial injury" is entitled to be retired for disability.

Any patrol, state safety, state industrial, state peace officer/firefighter, or local safety member incapacitated for the performance of duty as the result of an industrial disability shall be retired for disability, pursuant to this chapter, regardless of age or amount of service.

(Gov. Code, § 21151, subd. (a).)

(a)(1) If the medical examination and other available information show to the satisfaction of the board, or in case of a local safety member, other than a school safety member, the governing body of the contracting agency employing the member, that the member in the state service is incapacitated

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

(2) In determining whether a member is eligible to retire for disability, the board or governing body of the contracting agency shall make a determination on the basis of competent medical opinion and shall not use disability retirement as a substitute for the disciplinary process. ...

(Gov. Code, § 21156.)

2. Government Code section 20026 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, or in the case of a local safety member by the governing body of the contracting agency employing the member, on the basis of competent medical opinion.

(In *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876, the court stated: [“We hold that to be ‘incapacitated for the performance of duty’ within section 21022⁵ means the *substantial* inability of the applicant to perform his usual duties.”]; italics original.)

3. When a member has been retired for disability prior to the minimum age at which he can voluntarily retire for service, CalPERS may require the member to undergo a medical examination.

The board, or in case of a local safety member, other than a school safety member, the governing body of the employer from whose employment the person was retired, 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, and upon his or her application for reinstatement, shall cause a medical examination to be made of the recipient who is at least six months less than the age of compulsory retirement for service applicable to members of the class or category in which it is proposed to employ him or her. The board, or in case of a local safety member, other than a school safety member, the governing body of the employer from whose employment the person was retired, shall

⁵ Predecessor to Government Code section 20026.

also cause the examination to be made upon application for reinstatement to the position held at retirement or any position in the same class, of a person who was incapacitated for performance of duty in the position at the time of a prior reinstatement to another position. The examination shall be made by a physician or surgeon, appointed by the board or the governing body of the employer, at the place of residence of the recipient or other place mutually agreed upon. 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, the university, or contracting 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.

(Gov. Code, § 21192.)

4. If the member is determined to no longer be substantially incapacitated for performing his usual duties, he shall be reinstated to her former position.

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.

If the recipient was an employee of the state or of the university and is so determined to be not incapacitated for duty in the position held when retired for disability or in a position in the same class, he or she shall be reinstated, at his or her option, to that position. However, in that case, acceptance of any other position shall immediately terminate any right to reinstatement. A recipient who is found to continue to be incapacitated for duty in his or her former position and class, but not incapacitated for duty in another position for which he or she has applied for reinstatement and who accepts employment in the other position, shall upon subsequent discontinuance of incapacity for service in his or her former position or a position in the same class, as determined by the board under Section 21192, be reinstated at his or her option to that position.

If the recipient was an employee of a contracting agency other than a local safety member, with the exception of a school safety member, the board shall notify it that his or her disability has terminated and that he or she is eligible

for reinstatement to duty. The fact that he or she was retired for disability does not prejudice any right to reinstatement to duty which he or she may claim.

(Gov. Code, § 21193.)

5. The following are the minimum ages at which a member may voluntarily retire for service:

A member shall be retired for service upon his or her written application to the board if he or she has attained age 50 and is credited with five years of state service, except as provided in Sections 21061, 21062, and 21074.

(Gov. Code, § 21060, subd. (a).)

A local safety member, other than one subject to Section 21362 or 21362.2, shall be retired for service upon the member's written application to the board if the member has attained the age of 55 years, and is credited with five years of state service.

(Gov. Code, § 21061, subd. (a).)

Notwithstanding Section 21061, a local safety member to whom Section 21061 applies shall be retired for service upon his or her written application to the board if he or she has attained age 50 and is credited with five years of state service.

However, if the member retires before attaining age 55, his or her prior and current service pensions shall be reduced to that amount that the value of the pensions as deferred to that minimum age will purchase at the actual age of retirement on the basis of the mortality tables and actuarial interest rate in effect with respect to those members.

(Gov. Code, § 21062.)

A state member who became subject to the Second Tier shall be retired for service upon his or her written application to the board if he or she has attained age 55 and is credited with 10 years of state service.

(Gov. Code, § 21074.)

6. By virtue of his employment as a Correctional Supervising Cook working for CDCR, Respondent was a state safety member of CalPERS. Pursuant to Government Code sections 20026, 21151, subdivision (a), and 21156, subdivision (a), he was retired for disability effective October 6, 2010.

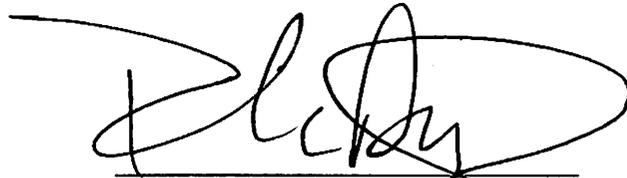
7. Because Respondent was under the minimum age for voluntary service retirement at the time of her disability retirement,⁶ he was subject to the provisions of Government Code section 21192.

8. As noted in Finding 17, Dr. Segil did not provide an analysis of his physical Findings of his examination of Respondent with Respondent's usual and customary duties as a Correctional Supervising Cook. Thus, there is insufficient competent medical evidence to determine that Respondent is not currently physically incapacitated for the performance of his usual duties as a Correctional Supervising Cook for CDCR, and that is what CalPERS must establish before it can divest Respondent of his disability retirement, a retirement which Dr. Segil conceded was appropriate at the time it was granted. Therefore, CalPERS has failed to meet its burden and Respondent's appeal from CalPERS' determination that he should be reinstated to his former position should be granted.

ORDER

Montell D. Pierce's appeal from CalPERS' determination that he be reinstated to his former position as a Correctional Supervising Cook with CDCR is granted.

DATED: 9-25-15



RALPH B. DASH
Administrative Law Judge
Office of Administrative Hearings

⁶ There was no evidence of the minimum age for voluntary retirement for service for a Correctional Supervising Cook. However, Respondent will not be 50 years old until next year (Factual Finding 6), and the youngest age at which any member may voluntarily retire for service is 50 (Legal Conclusion 5).