

ATTACHMENT A
THE PROPOSED DECISION

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

In the Matter of the Application for Disability
Retirement of:

DARLENE S. PARKER,

Respondent,

and

SAN JOAQUIN COUNTY SCHOOLS,

Respondent.

Case No. 2014-1199

OAH No. 2015050674

PROPOSED DECISION

This matter was heard before Tiffany L. King, Administrative Law Judge, Office of Administrative Hearings, State of California, on December 7, 2015, in Sacramento, California.

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

Darlene S. Parker (respondent) was present and represented herself. There was no appearance by or on behalf of the San Joaquin County Schools (County).

Evidence was received, the record was closed, and the matter was submitted for decision on December 7, 2015.

ISSUE

On the basis of orthopedic (neck), rheumatologic (fibromyalgia and chronic fatigue) and psychiatric (anxiety, depression, concentration) conditions, is respondent permanently and substantially incapacitated from performing her usual duties as an Account Specialist for the County?

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM

FILED Jan. 4, 2016

C. Bodily

FACTUAL FINDINGS

1. Respondent was employed as an Account Specialist by the County's Office of Education. By virtue of her employment, she is a state miscellaneous member of CalPERS and subject to Government Code section 21150.¹ Respondent has the minimum service credit necessary to qualify for retirement.

2. On June 10, 2013, respondent filed an application for disability retirement with the Benefits Services Division of CalPERS. In her application, respondent indicated that she was retiring for service pending disability retirement, and designated October 1, 2013, as her retirement date. Respondent described her disability as "fibromyalgia with chronic fatigue, carpal tunnel syndrome [and] nerve damage both arms." Respondent asserted her disability occurred in approximately 2003, and that she was diagnosed five to six years later. Regarding how her disability occurred, respondent explained that it occurred "over a long period of time, I sought treatment for various symptoms – diagnosis came after several years."

3. After reviewing respondent's application, CalPERS retained three experts to conduct independent medical examinations (IMEs) of respondent's asserted orthopedic, rheumatologic, and psychiatric conditions. After reviewing the IME reports, CalPERS determined that respondent was not permanently and substantially incapacitated from the performance of her duties as an Account Specialist.

4. By letter dated February 27, 2014, CalPERS notified respondent of its determination and advised her of her appeal rights. Respondent filed an appeal and request for hearing on March 27, 2014. Thereafter, CalPERS received additional medical records from respondent's medical providers. CalPERS forwarded these records to its three medical experts and requested supplemental IME reports. The supplemental IME reports confirmed CalPERS determination that respondent was not permanently and substantially incapacitated from performing her job duties. Accordingly, CalPERS filed the Statement of Issues in its official capacity on April 13, 2015.

Duties and Physical Requirements of an Account Specialist

5. Respondent was employed by the County in its Office of Education from June 2003 until her voluntary separation on March 22, 2013. The County's Job Description defines the Account Specialist position as one who "performs difficult and complex accounting and auditing duties." Essential functions of the position include: "(1) assist in the coordination of budget development, complete, prepare and analyze information and data

¹ Government Code section 21150 provides: "Any member incapacitated for the performance of duty shall be retired for disability pursuant to this chapter if he or she is credited with five years of state service, regardless of age, unless the person has elected to become subject to Section 21076 or Section 21077."

related to income and expenditures; (2) coordinate communication between the business office and various District/County Office departments and personnel, provide information related to financial accounting procedures, account balances, budgets, records and related matters; (3) perform highly specialized accounting and budgetary functions; (4) conduct internal audits of financial accounts, assist outside auditors in conducting audits of financial records; (5) prepare various financial accounting and budget control documents [*sic*] reports, prepare invoices for services provided to other agencies; (6) maintain confidentiality; [and] (7) related duties as assigned.”

6. CalPERS submitted a form entitled Physical Requirements of Position/Occupational Title which was signed by respondent and Karen DePrater, Human Resources Director, on May 22, 2013. According to this form, an employee in respondent’s position: (1) never runs, crawls, kneels, climbs, power grasps, lifts more than 10 pounds, walks on uneven ground, works with heavy equipment, is exposed to extreme temperatures, humidity, wetness, dust, gas, fumes, or chemicals, works at heights, operates foot controls, engages in repetitive movement, uses special visual or auditory protective equipment, or works with bio-hazards; (2) occasionally (up to three hours a day) stands, walks, squats, bends and twists at the waist, reaches above the shoulder, pushes and pulls, lifts up to 10 pounds, and drives; and (3) frequently (three to six hours a day) sits, engages in fine manipulation, repetitively uses her hands, uses a keyboard and mouse, and is exposed to excessive noise.

Reports and Testimony of CalPERS’ Experts

7. CalPERS retained Douglas Haselwood, M.D., Gary L. Cavanaugh, M.D. and Arthur M. Auerbach, M.D to conduct IMEs of respondent’s rheumatologic, psychiatric, and orthopedic conditions, respectively.

8. Douglas Haselwood, M.D. Dr. Haselwood is board-certified in rheumatology. He examined and took a medical history from respondent on September 19, 2013. He also reviewed respondent’s medical records, position duty statement, and Physical Requirements of Position/Occupational Title form, and wrote an IME report dated September 20, 2013. At the time of the IME, respondent was 53 years old. Respondent informed Dr. Haselwood that she experienced “constant moderate-to-severe widespread musculoskeletal pain” which was most problematic in her upper back. Respondent also described having chronic, mild-to-severe fatigue, frequent headaches, chronic depression/anxiety associated with life stressors, and difficulty with cognition and memory. Respondent disclosed that she lived alone and was able to maintain independent living and homemaking activities such as driving, watching television, socializing, and spending time with her granddaughter.

9. Dr. Haselwood noted that respondent’s appendicular joint examination was “normal without consistent joint tenderness or evidence of a chronic or active arthritis/synovitis.” Respondent reported tenderness over the posterior head and neck with limiting motion, and soft tissue tenderness over the trunk and extremities. However, Dr. Haselwood found that, after repeated testing, “this soft tissue tenderness was too inconsistent

and poorly localized to allow any credible mapping of tender points.” He also noted that respondent’s “discomfort, guarding, and withdrawal mechanisms were somewhat inconsistent and nonphysiologic.”

10. Dr. Haselwood diagnosed respondent as follows: “chronic, widespread musculoskeletal pain, dysfunction and fatigue syndrome presumptively representing the cumulative effect of: (a) Age-appropriate degenerative mechanical musculoskeletal phenomena including osteoarthritis and degenerative disease to the neck; (b) Widespread myofascial discomfort with a hypervigilance for same historically characterized as fibromyalgia; [and,] (c) A significant element of a nonorganic amplification presumptively associated with chronic depression/anxiety in conjunction with on-going life stressors, occupational and otherwise.”

11. Dr. Haselwood found that respondent “does have some legitimate, albeit generally age-appropriate, sources of musculoskeletal discomfort.” However, he could not confirm that respondent suffered from fibromyalgia because the “unusually high and incapacitating level of widespread musculoskeletal pain, dysfunction, and fatigue and the resulting high levels of physical impairments” perceived by respondent, were “based almost entirely, on self-assertion and subjective criteria.” He explained that the American College of Rheumatology arbitrarily defined fibromyalgia syndrome “as a mechanism for characterizing studying patients with cryptogenic musculoskeletal pain” and that it was “never intended to serve as a mechanism for determining levels of impairment/disability in the medical legal setting.” Because it is based on self-reporting only, there is “no objectively based mechanism for determining the actual ‘severity’ of fibromyalgia in any given individual.” Additionally, Dr. Haselwood noted that respondent’s condition is complicated by her history of “mental health issues with depression/anxiety,” which “in the context of life stressors may be significantly compromising her support and coping mechanisms for dealing with otherwise relatively benign musculoskeletal hardship” in her job setting. Dr. Haselwood concluded that “it appears [respondent’s] health care providers are using the syndrome of fibromyalgia as a convenient ‘default diagnosis’ to characterize the more complex physical and mental health problems most of which have nothing to do with musculoskeletal pathophysiology.”

12. Dr. Haselwood concluded that respondent possessed the “physical capabilities of participating in full time sedentary work” as an Account Specialist, though he noted that respondent may lack the “psychologic stamina to deal with the rigors of full time employment... .” He found that there were no specific job duties that respondent was unable to perform.

13. Thereafter, CalPERS requested that Dr. Haselwood review additional medical records from respondent’s medical providers and provide a supplemental report. In his supplemental report dated July 18, 2014, Dr. Haselwood noted that the additional medical records do “not cause me to change any of the findings and conclusions regarding [respondent]” which he presented in his original IME report dated September 20, 2013.

14. Dr. Haselwood testified at hearing in a manner consistent with his IME and supplemental IME reports. In sum, Dr. Haselwood opined that respondent was not substantially incapacitated by a rheumatologic condition from performing the usual duties of an Account Specialist.

15. Gary L. Cavanaugh, M.D. Dr. Cavanaugh is board-certified in psychology. On September 27, 2013, he took respondent's personal and medical histories, and performed a mental status examination. He also reviewed respondent's medical records, position duty statement, and Physical Requirements of Position/Occupational Title form. Dr. Cavanaugh issued an IME report dated October 22, 2013. At the time of the IME, respondent was 54 years old.

16. Dr. Cavanaugh observed that respondent reported on time for the IME, and was "alert, spontaneous, and cooperative with the assessment." He further noted she was "neatly dressed and groomed and appeared involved with the evaluation process." During the examination, respondent reported feelings of sadness, hopelessness, and disappointment. She also described having low energy, sleep disturbance, and decreased concentration and memory. Respondent complained of pain in her anterior thighs, shoulders, neck, head, wrist, and both arms, and that said pain disrupted her ability to sleep. She also reported having difficulty falling asleep without medication, but that she was able to sleep adequately if she took Xanax.

17. Respondent related to Dr. Cavanaugh that she had suffered from depression for approximately 25 years, and had tried different antidepressants with varying degrees of effectiveness. In August 2013, respondent began taking Effexor XR which has helped improve her depression. At the time of the examination, respondent's medications included: 112.5 milligrams of Effexor XR daily; 150 milligrams of bupropion twice a day; 0.25 milligrams of alprazolam two to three times a day; 100 milligrams of Lyrica daily; and Nucynta for breakthrough pain three times a day. She also took Kadian, an opiate pain medication, and Xanax for sleeping.

18. Dr. Cavanaugh made the following DSM-IV diagnoses:

Axis I:	Dysthymic Disorder, in partial remission; Pain Disorder with General Medical and Emotional Components
Axis II:	Personality Disorder, not Otherwise Specified, with Co-Dependent and Dependent Traits
Axis III:	Fibromyalgia, by history; migraines; carpal tunnel syndrome

19. Dr. Cavanaugh explained his diagnostic findings as follows:

[Respondent] indicated that since her primary care physician has started her on another antidepressant medication, Effexor XR, currently at 112.5 mg daily, her depression has improved and, "It's helping a lot." At the time of my evaluation, her

dysthymic disorder was judged to be mild to possibly moderate and producing slight impairment by itself. Her primary problems appear to be related to her pain disorder which arises from longstanding fibromyalgia with attendant pain as well as concentration and memory problems and fatigue, and to some extent from her migraines which have improved, and to a less [*sic*] degree the residuals from her carpal tunnel surgery. Fibromyalgia in itself is not specifically a psychiatric diagnosis, and thus the memory, concentration and fatigue problems associated with it are, by definition, not caused by a psychiatric disorder. Her pain disorder, which has medical contributions (fibromyalgia, migraines, carpal tunnel) and psychological factors, is a second component to the impairment she complains of. I have concerns about chronic treatment of this with opiates and opiate agonists, since they could cause symptoms of fatigue, lack of energy, and concentration and focus problems. Thus, it is my opinion that the impairments she describes are at the present time actually a result of non-psychiatric disorders, namely symptoms of fibromyalgia and the effects of her pain treatment. The psychiatric components of her pain disorder, in my opinion, are primarily related to her personality function, with dependent and co-dependent features which are associated with at least a moderate degree of somatization and, in the past to at least a partial degree, her depressive disorder which she indicates is considerably improved at the present time.

20. Dr. Cavanaugh opined that there were no specific job duties which respondent was unable to perform because of a mental condition, and that respondent was not “unable to perform the usual duties of her job because of a psychiatric condition.” Specifically, Dr. Cavanaugh found that respondent’s depression was significantly improved, and that her energy, concentration and memory problems resulted from “a combination of her fibromyalgia and treatment of her pain symptoms from the fibromyalgia, carpal tunnel syndrome, and migraines... .”

21. Thereafter, CalPERS requested that Dr. Cavanaugh review additional medical records from respondent’s medical providers and provide a supplemental report. In his supplemental report dated October 8, 2014, Dr. Cavanaugh asserted that the additional records did not change his opinion as set forth in his original IME report.

22. Dr. Cavanaugh’s testimony was consistent with his IME report and supplemental report. He also testified that respondent’s appearance and actions during the examination were inconsistent with someone suffering from severe depression or severe functional problems. For example, Dr. Cavanaugh opined that someone who has severe depression or severe functional problems would be poorly groomed, apathetic, lacking in energy and motivation, and unable to concentrate. On the contrary, respondent was well-

groomed, alert, and fully involved with the evaluation process. There was no indication she had deficits in her memory or concentration. Dr. Cavanaugh further opined that respondent's anxiety about her future was consistent with someone who had recently lost his or her job.

23. Arthur M. Auerbach, M.D. Dr. Auerbach is board-certified in orthopedic surgery. He examined respondent on December 9, 2013, reviewed her medical records and clinical history, and issued an IME report dated December 16, 2013.

24. On the date of the examination, respondent complained of increasing neck pain and stiffness over the past eight years. She also reported experiencing severe neck pain followed by headaches while at work, as well as neck spasms in the shoulder blade musculature, for which respondent received trigger point injections in her shoulder blade and posterior neck by a pain management specialist. For the past five years, respondent felt pain in both wrists as well as numbness and tingling into the fingers of both hands. A recent nerve conduction study of respondent's wrists evidenced right and left carpal tunnel syndrome. Respondent was given a wrist splint to use at night as well as anti-inflammatory medications. Notwithstanding the pain and numbness in her wrists and hands, respondent told Dr. Auerbach she could perform her regular workload as an Account Specialist.

25. During the examination, Dr. Auerbach found no obvious atrophy of respondent's shoulders, neck, arms, forearms, or hands. Respondent had some but "not much" loss of cervical rotation, and examination of her elbow motions did not evidence any nerve root irritation. Respondent was able to make a fist with both hands and extend her fingers normally. Her hand grip strength was within the normal limits for her age, which Dr. Auerbach testified was unusual for persons suffering from carpal tunnel syndrome. Dr. Auerbach also tested respondent's muscle and motor strength against resistance in her shoulders, elbows, forearms and fingers, with normal results. Finally, Dr. Auerbach found normal gross sensation in respondent's upper extremities, wrists, hands, and fingers. Respondent had numbness in all fingers of her right hand, and a "very mild" degree of bilateral carpal tunnel syndrome.

26. Dr. Auerbach diagnosed respondent with: probable chronic cervical strain; probable diffuse cervical degenerative disc disease; and, history by patient of chronic bilateral syndrome with positive nerve conduction studies. Dr. Auerbach explained,

[Respondent] has a history of chronic bilateral carpal tunnel syndrome with positive nerve conduction studies as well as chronic cervical strain with a degree of diffuse cervical degenerative disc disease.

[Respondent's] neck and bilateral wrist and hand problems have stabilized. It is to be noted that I do not have any records referring specifically to her neck, bilateral wrists and hands.

27. Dr. Auerbach opined that there are no specific job duties which respondent cannot perform because of an orthopedic condition in her neck, wrists, or hands. He continued, “[s]he can do the job of an Account Specialist orthopedically but with neck pain and with bilateral wrist pain and intermittent numbness into the fingers of the right greater than left hand when typing.” In Dr. Auerbach’s professional opinion, respondent was “not substantially incapacitated for the performance of her usual duties” based upon her orthopedic conditions.

28. Thereafter, Dr. Auerbach reviewed additional medical records from respondent’s medical providers and provide a supplemental report. In his supplemental report dated July 21, 2014, Dr. Auerbach asserted that the additional information did not change his opinion that respondent was not substantially incapacitated based upon her orthopedic conditions.

Respondent’s Testimony and Evidence

29. Respondent and her former mother-in-law and father-in-law testified at hearing. Respondent did not call any health care providers to testify, nor did she offer any medical records or reports to evidence her asserted conditions. However, the IME reports provided by CalPERS experts summarized the medical records which respondent had submitted to CalPERS by Rassia Hill, D.O. (her primary care physician), Madelaine Aquino, M.D. (her pain management specialist), and Christina D. Howells, LCSW (her counselor). CalPERS also offered into evidence supplemental records from Dr. Aquino and Ms. Howells.

30. At hearing, respondent testified that she was excited to accept the new job as an Account Specialist with the County in June 2003. Shortly after she started, however, she began experiencing migraines and other headaches on a regular basis. Dr. Hill prescribed her medication to control the pain. After taking the medication, respondent had to lie down in her car for an hour before she was able to work. Dr. Hill continued to treat respondent for her migraines, as well as neck pain, shoulder and back spasms. Sometime between 2005 and 2007, Dr. Hill diagnosed respondent with fibromyalgia and chronic fatigue and prescribed Lyrica in addition to respondent’s other pain medication. Dr. Hill also referred respondent to Dr. Aquino for pain management. Respondent informed her employer of her diagnosis.

31. Lyrica lessened the severity of, but did not eliminate, respondent’s symptoms. Still, respondent performed well in her job and received positive performance reviews. In 2009, changes in departmental operations resulted in different responsibilities for the Account Specialist position, and respondent began having conflicts with her supervisor. The physical layout of the office also changed and respondent’s cubicle was moved close to the kitchen. All of these changes caused respondent considerable stress. Her medical symptoms were aggravated and began to affect her work adversely. Her supervisor noted that respondent’s accuracy on her assignments had deteriorated as she was not double-checking her work, that she was frequently tardy, and that she was away from her desk for an unacceptable amount of time. Respondent’s supervisor agreed to allow respondent to start

her shift a half hour later, but respondent's tardiness persisted. Respondent began to have difficulty remembering routine procedures for her job, requiring her to ask co-workers for help. In 2012, respondent took a medical leave of absence. When she returned to work, her performance problems persisted. She was placed on performance probation for one year. During this time, respondent suffered from "severe pain, extreme anxiety and stress, [and] chronic fatigue." She had to go to bed immediately after work, and spent her weekends in bed in order to be able to return to work the following Monday. Respondent's performance improved temporarily, but then began to deteriorate again.

32. In March 2013, respondent's employer advised her of her options to resign, or to apply for service retirement or service retirement pending disability retirement. If respondent did not retire or resign, her employer advised it would institute termination proceedings against her. As set forth in Fact Finding 2, above, respondent elected to apply for service retirement pending disability retirement.

33. Respondent's former in-laws, Ted and Pat Parker, each testified that respondent had worked for them from 1977 to 1988. During this time, she was an "exceptional employee" and eventually was "in charge of the whole office." In November 2013, the Parkers re-hired respondent as their office manager. However, respondent did not perform well. Shocked at respondent's deterioration and inability to perform the basic skills of the job she had perfected so many years before, the Parkers reluctantly terminated her employment.

34. Dr. Hill: In a physician's report on disability to CalPERS, dated June 13, 2013, Dr. Hill noted respondent's primary diagnosis of fibromyalgia and depression, and secondary diagnosis of cervical disc disease with chronic migraine headaches. Dr. Hill opined that respondent was permanently incapacitated from performing the job duties of her sedentary occupation due to chronic pain, headaches, and depression. Dr. Hill's report did not identify the criteria she used in reaching her opinion or diagnoses.

35. In a physician's report on disability to CalPERS, dated August 7, 2013, Dr. Hill noted that respondent's "illness/injury" occurred on March 16, 2004, and that respondent was unable to perform her job duties since March 22, 2013. Respondent's last exam date was July 25, 2013. Respondent experienced chronic pain, headaches, fatigue and poor concentration. Dr. Hill confirmed her diagnoses of fibromyalgia, depression, cervical disc degeneration and chronic migraines. Dr. Hill also confirmed her opinion that respondent was permanently and substantially incapacitated from performing the duties of her job.

36. Ms. Howells: In a June 13, 2013 report, Ms. Howells listed respondent's primary diagnosis of dysthymia and adjustment disorder with anxiety and depression, and a secondary diagnosis of fibromyalgia. She opined that respondent is permanently incapacitated from the performance of her sedentary work. In a July 17, 2013 letter to CalPERS, Ms. Howells described respondent as having dysthymic disorder and described respondent's mental health symptomology. She also noted that respondent experienced continued pain, some depression, anxiety, feelings of helplessness, and stress at work.

Respondent's symptoms were exacerbated by her work problems and family conflicts, including grieving after her father's death in January 2013. Ms. Howells noted, however, that respondent was more assertive and less emotionally reactive in February 2013.

37. In a July 25, 2013 disability form, Ms. Howells confirmed her diagnosis of dysthymic disorder and described respondent's symptoms as periodic depressed feelings, isolation, withdrawal, lethargy, somnolence, and poor concentration. Ms. Howells noted respondent had difficulty focusing on tasks which require accurate math calculations and meeting deadlines. Ms. Howells further noted that respondent had difficulty with treatment focus, depression, anxiety, and stress management.

38. Dr. Aquino: In a progress report dated June 4, 2013, Dr. Aquino noted an increase in respondent's Lyrica dosage. Respondent complained of tremors in her left hand, reported a pain level of 3 out of 10, and admitted she had not been using her brace at night. Dr. Aquino concluded respondent suffered from myalgia and myositis, chronic pain syndrome, vitamin-D deficiency, SI-gluteal strain, and carpal tunnel syndrome. An incomplete physician's report on disability, dated June 17, 2013, noted respondent's diagnoses as fibromyalgia and vitamin-D deficiency. However, Dr. Aquino made no finding that respondent was substantially incapacitated from performing the usual duties of her job. In a progress report, dated August 2, 2013, Dr. Aquino listed respondent's condition as stable and reported pain level as 3 out of 10. She noted that respondent was seeing a rheumatologist for treatment of fibromyalgia. Dr. Aquino confirmed her diagnoses of myalgia and myositis, chronic pain syndrome, vitamin-D deficiency, SI-gluteal strain, and carpal tunnel syndrome. Finally, in her written response to CalPERS' questions, dated August 26, 2013, Dr. Aquino noted that respondent's present injury occurred in 2010 and was a gradual onset. Her first visit was on November 24, 2010, and last visit was on August 2, 2013. Notably, Dr. Aquino noted "N/A" in response to the question calling for the date respondent was unable to perform her usual duties.

Discussion

39. Respondent sought disability retirement on the basis of her alleged orthopedic, rheumatologic, and psychiatric conditions. No competent medical evidence was presented at the hearing to establish that respondent was substantially incapacitated to perform the usual duties of an Account Specialist due to these conditions. The IME reports and testimony of Drs. Haselwood, Cavanaugh, and Auerbach were persuasive that respondent is not substantially incapacitated. The curriculum vitae of these physicians demonstrate that they have the expertise to formulate the opinions they offered. Conversely, the medical records of respondent's medical providers (as summarized by CalPERS' experts) were incomplete, wholly conclusory, or otherwise insufficient to establish that respondent is substantially incapacitated from performing the usual duties of an Account Specialist. None of respondent's medical providers testified at the hearing to offer otherwise competent medical opinion that respondent was substantially incapacitated. The lay testimony of respondent and the Parkers concerning respondent's disability were insufficient to establish respondent's substantial incapacity. (*Peter Kiewitt Sons v. Industrial Accident Commission* (1965) 234

Cal.App.2d 831, 838 [“Where an issue is exclusively a matter of scientific medical knowledge, expert evidence is essential to sustain a commission finding; lay testimony or opinion in support of such a finding does not measure up to the standard of substantial evidence.”].)

40. Respondent had the burden to present competent medical evidence to establish that she is permanently and substantially incapacitated for the performance of her usual job duties. When all the evidence is considered, respondent failed meet her burden. Therefore, her disability retirement application must be denied.

LEGAL CONCLUSIONS

1. Respondent has the burden of proving she qualifies for disability retirement, and she must do so by a preponderance of the evidence. (*McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051-1052, fn. 5.) Evidence that is deemed to preponderate must amount to “substantial evidence.” (*Weiser v. Board of Retirement* (1984) 152 Cal.App.3d 775, 783.) To be “substantial,” evidence must be reasonable in nature, credible, and of solid value. (*In re Teed’s Estate* (1952) 112 Cal.App.2d 638, 644.)

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

“Disability” and “incapacity for performance of duty” as the 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. Government Code section 21156, subdivision (a), provides, in pertinent part:

(1) If the medical examination and other available information show to the satisfaction of the board ... 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

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

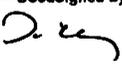
4. The courts have interpreted the phrase “incapacitated for the performance of duty” to mean “the substantial inability of the applicant to perform his usual duties.” (*Mansperger v. Public Employees’ Retirement System* (1970) 6 Cal.App.3d 873, 876.) Here, respondent failed to meet her burden of establishing, based upon competent medical opinion,

that she is substantially incapacitated for the performance of her usual duties as an Account Specialist with the County due to an orthopedic, rheumatologic, or psychiatric condition. Therefore, her disability retirement application must be denied.

ORDER

The application of Darlene S. Parker's application for disability retirement is DENIED.

DATED: December 31, 2015

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TIFFANY L. KING
Administrative Law Judge
Office of Administrative Hearings