

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 Industrial
Disability Retirement of:

ARMIDA S. HERNANDEZ,

Applicant,

and

CALIFORNIA DEPARTMENT OF
CORRECTIONS AND REHABILITATION,
CALIFORNIA STATE PRISON-
CORCORAN,

Respondent.

Case No. 2014-1145

OAH No. 2015020442

PROPOSED DECISION

Administrative Law Judge Stephen J. Smith (ALJ), Office of Administrative Hearings, State of California, heard this matter in Fresno, California, on September 29, 2015.

Preet Kaur, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Armida S. Hernandez (applicant) appeared and was represented by Ellen Mendelson, Attorney at Law.

Respondent California Department of Corrections and Rehabilitation, California State Prison-Corcoran, did not appear.

Evidence was taken, and the record was left open for receipt of:

- a. A translation of a MRI offered by applicant written in Spanish;
- b. A Supplemental Report from Dr. Ha'Eri, commenting on the translated MRI report once received by him;

- c. An opportunity for applicant's physician, Dr. Garcia, to review and comment and/or issue a Supplemental Report, if desired, on Dr. Ha'Eri's Supplemental Report; and
- d. For receipt of written closing arguments from the parties including their comments on the additional evidence.

The translated MRI was received on October 19, 2015, was marked as an applicant's Exhibit, and made a part of the record.

Opening arguments were received on January 15, 2016.

Reply argument from CalPERS was received February 5, 2016.

Time for applicant's reply argument was extended to February 26, 2016, at which time the reply was received. The arguments were each marked and made part of the record.

The record was closed and the matter was submitted on February 26, 2016.

ISSUES

Is applicant substantially incapacitated from the performance of her duties as a Clinical Social Worker (CSW) for respondent California Department of Corrections and Rehabilitation (CDCR) as a result of the orthopedic condition of her wrists and hands, lower back, right knee and right ankle, or the cumulative effect of some or all of these?

If applicant is substantially incapacitated as the result of some or all of her orthopedic conditions, was her condition industrially caused; caused or significantly attributable to workplace injuries and/or work conditions?

SUMMARY OF RESOLUTION OF ISSUES

Applicant failed to prove by a preponderance of the credible and persuasive medical evidence produced that she is substantially incapacitated from the performance of her duties as a CSW for CDCR as a result of the orthopedic condition of her wrists and hands, lower back, right knee and right ankle, and/or the cumulative effect of them.

Applicant failed to prove that there was a meaningful causation relationship between her complaints of pain, disability and incapacity and workplace injuries and/or workplace conditions. The credible and persuasive medical evidence adduced in this matter supports only a conclusion that the pain, disability and incapacities of which applicant complains are the product of factors other than her work or work injuries.

Burden of Proof and Production of Evidence

“As in ordinary civil actions, the party asserting the affirmative in an administrative hearing has the burden of proof going forward and the burden of persuasion by a preponderance of the evidence.”¹ It has been repeatedly held that the applicant for a disability retirement must prove eligibility for the benefit, including presenting satisfactory evidence of substantial incapacity to perform the usual and customary duties of his or her position.² An applicant for a CalPERS disability retirement bears the burden of proof and the burden of going forward with the evidence.³ *Mansperger* requires the applicant for disability retirement to prove by a preponderance of evidence that he or she is “substantially incapacitated” from the performance of his or her usual and customary duties.⁴ A preponderance of the evidence is that state of evidence where proof of the existence or nonexistence of a fact in dispute is more likely than not.⁵ Evidence that is deemed to preponderate must amount to “substantial evidence.”⁶ Evidence must be reasonable in nature, credible, and of solid value in order to be “substantial.”⁷ Applicant’s contention in closing, that “CalPERS bears the burden of proof that Hernandez is not disabled, or that the disability did not arise from her employment. These are affirmative defenses, which CalPERS must prove by substantial evidence,”⁸ is rejected as lacking any legal support or merit.

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¹ *McCoy v. Board of Retirement* (1986) 183 Cal.App. 3d 1044, 1051.

² *Id.*, *Glover v. Board of Retirement* (1989) 214 Cal.App.3d 1327, 1332, *Mansperger v. Public Employees’ Retirement System* (1970) 6 Cal.App. 3d 873, 876.

³ *Id.*, *Harmon v. Board of Retirement* (1976) 62 Cal.App. 3d 689, 691, *In Re: Theresa V. Hasan*, Board of Administration of the California Public Employees’ Retirement System Precedential Decision No. 00-01.

⁴ *Mansperger, supra.*

⁵ Evidence Code section 115.

⁶ *Weiser v. Board of Retirement* (1984) 152 Cal.App.3d 775, 783.

⁷ *In re Teed’s Estate* (1952) 112 Cal.App.2d 638, 644.

⁸ Applicant’s Opening Brief 2:16-18

FACTUAL FINDINGS

Procedural and Jurisdictional Findings

1. Applicant was employed by the California Department of Corrections and Rehabilitation (CDCR), as a Clinical Social Worker (CSW), assigned to the Corcoran State Prison, at all times relevant to this Decision. Applicant has been and remains a state safety member of CalPERS. Applicant had the minimum service credits to qualify for a service retirement at the time of her applications (below).
2. Applicant applied to CalPERS for both an industrial disability retirement (IDR) and a service retirement pending a decision on her application for IDR on August 30, 2013. Applicant's effective retirement date for service was August 30, 2013. Applicant has received a service retirement benefit since the effective date of her retirement for service.
3. Applicant claimed in her application for IDR that she is disabled and unable to perform her duties as a CSW for CDCR because of her orthopedic condition caused by injuries to her lower back and wrists.
4. Applicant described her disability in her application:

Inability to use my hands repetitively to type. Inability to walk, stand, sit for more than 15-20 minutes without discomfort severe back pain.
5. Applicant wrote in her IDR application that her disability occurred on November 20, 2012, when she lost her balance while at work "coming down the stairs," fell and sprained her right ankle and knee, causing pain "shooting down on my legs." She reported experiencing sharp pain in her lower back.
6. Applicant described her limitations/preclusions because of her claimed disabling conditions by simply stating that she is unable to perform her duties. She wrote in her application that she is not currently working in any capacity.
7. Applicant added in the section entitled "Other information you would like to provide," that she got hurt in prison for the first time on July 27, 2009. She "had an accident" in June 2011, but continued working. She wrote that after the incident on November 20, 2012, "I was unable to function."
8. Applicant submitted medical records and other documentation to support her disability claim to CalPERS's Benefits Services Division (BSD). These medical records were from her primary care physician, Reynaldo Garcia M.D., and from other health care practitioners treating or evaluating her in conjunction with her Workers Compensation claims. Applicant submitted Physician's Reports on Disability, completed on CalPERS

forms, by Kevin Calhoun, M.D., a general practitioner and Lorene Flaherty, D.P.M., a podiatrist, and a report by Craig Maclean, M.D.

9. Applicant's medical records were received by the staff of CalPERS' BSD and forwarded for consideration to G.B. Ha'Eri, M.D., a Board certified orthopedic surgeon retained by CalPERS to perform an Independent Medical Evaluation (IME). Dr. Ha'Eri performed his orthopedic IME of applicant on April 5, 2014. Dr. Ha'Eri made his first IME report to CalPERS' BSD on the same date, and issued a Supplemental Report dated May 24, 2014, after reviewing a Residual Functional Capacity Questionnaire completed by Dr. Garcia dated April 7, 2014.

10. CalPERS' BSD staff reviewed the medical and other reports and concluded the medical information did not support granting the application. CalPERS's BSD notified applicant in writing on June 23, 2014, that she had failed to produce sufficient persuasive medical evidence to demonstrate that she was substantially incapacitated from her duties as a CSW with the CDCR, and that her application for a disability retirement was therefore denied. Applicant's service retirement benefit continued unimpaired.

11. Applicant timely appealed the CalPERS determination and denial of her application.

12. Diane Alsup, Interim Chief of CalPERS' BSD, made the allegations in the Statement of Issues in her official capacity and caused it to be filed. The Statement of Issues was made on February 6, 2015, and was served on applicant. Applicant timely filed a Request for Hearing on the Statement of Issues. The matter was set for an evidentiary hearing before an Administrative Law Judge (ALJ) of the Office of Administrative Hearings.

13. Notice of the date, time and place of the evidentiary hearing was duly given to the respondent CDCR. CDCR failed to appear. The matter proceeded as a default as to the CDCR, pursuant to the provisions of Government Code section 11520.

Usual and Customary Duties

14. Applicant's official CDCR Health Care Services Essential Functions List (Essential Functions), describes applicant's position as a CSW as one in which she functions under the general direction of the Senior Psychologist and Supervising CSW, making clinical intake assessments, providing treatment, crisis intervention and discharge of inmates in the CDCR inmate Mental Health Services Delivery Program. The Essential Functions List divides the position into three classifications of requirements, Administrative, Physical, and CSW Health/Correctional Facility Safety, and states that the CSW must always be ready, willing and able to perform all the essential functions in each of the classifications. Essential Administrative Functions required that are potentially impacted by applicant's orthopedic disability claims include:

Remain alert, focused and effectively evaluate and respond to dangerous or emergency situations in order to maintain a safe and secure environment for self and others, and anticipate problems (e.g., harm to self or others, escapes, change in inmates' mental functioning, etc.);

Communicate effectively, in speech and in writing, in person and by telephone, to disseminate information, respond to inquiries, provide direction and training, compose correspondence, create and update desk procedures, document appropriate information, including but not limited to, keeping accurate medical orders and medical records, and relay others (sic) to facilitate treatment of inmate patients; and

Perform all duties within the scope of licensed clinical social worker practice.

Essential Physical Functions required of incumbents in applicant's position are:

Have and maintain sufficient strength, agility and endurance to perform during stressful (physical, mental and emotional) situations without compromising health and well-being of self or others;

Access all floors of facilities with multiple levels separated by flights of stairs;

Stoop, bend, reach, twist and stretch occasionally to continuously, sufficiently to inspect, observe, manipulate, move and record objects 360 degrees horizontally or more, from floor through overhead levels;

Lift and carry, frequently light (20 pound maximum) to medium (50 pound maximum) loads;

Pushing and pulling, occasionally to frequently;

Perform regular duties on a wide range of working surfaces which may be uneven or rough, or become slippery due to weather or spillage of liquids;

Ability to accept fluctuations in inmate patient behavior and mental condition, adjust to changes in the correctional facility setting in hostile situations (i.e. lockdowns, riots, overcrowding,

etc.) and respond to changes in custody requirements, court mandates, Departmental Policies and Procedures, etc.;

Ability to move from work locations throughout all facilities;
and

Ability to drive electric carts in an emergency;

Essential CSW Health/Correctional Facility Safety Functions required of incumbents in applicant's position are:

Provide direct treatment to inmate patients in the caseload, including individual and group psychotherapy;

Ability to assess inmate-patient needs and provide crisis intervention including suicide assessments, brief intensive counseling and screens requests for services of inmate-patients;

Document care provided in medical records;

Ability to add, subtract, understand test reliability and validity of fundamental statistics;

Sit frequently to constantly during meetings while conducting assessments, evaluations and completing paperwork, usually sitting one half or more of the workday;

Participate in risk assessment, evaluation and recommendation for alternate level of care placement for release to the community or other case disposition;

Coordinate discharge planning activities and act as a resource on accessing appropriate community supported services to be realized upon release;

Respond to requests from clients/patients, family members, courts and community agencies;

Provide social work services to family members and community agencies; and

Consult with colleagues and other staff on behavior management treatment issues.

15. A Physical Requirements of Position description (Physical Requirements) for a CSW working for CDCR is found in Exhibit 13. The Physical Requirements description was signed by applicant and by a CDCR Return-to-Work coordinator on August 2 and August 5, 2013. The Physical Requirements description notes that applicant was required to sit constantly (over six hours per workday); to frequently (between three and six hours per workday) push and pull, use a keyboard and mouse, and lift from between zero and 50 pounds; and occasionally (up to three hours per workday), stand, walk, bend and twist at the neck and the waist, reach above and below shoulders, perform fine manipulation tasks, engage in simple grasping and repetitive use of hands, walk on uneven ground, and drive. Applicant hand-wrote at the bottom of the Physical Requirements description, "I had to drive golf cart to get from one location of the prison to the next which has foot controls and repetitive motion when typing."

On The Job Injury

16. Applicant lost her balance coming downstairs, turned her right ankle, twisted her right knee and fell on the stairs while working at Corcoran State Prison as a CSW November 20, 2012. She hurt her right knee and felt pain in her lower back. She sought medical attention at Visalia Occupational Therapy where she was treated by Dr. Torres and his nurse practitioner (NP). She had x-rays of her right ankle and foot, which proved negative for any broken bones. Applicant was diagnosed with a sprained right ankle, and a strained low back and right knee. She was provided pain and anti-inflammatory medication, referred to physical therapy, and was later medically approved to return to work.

Applicant's Testimony

17. Applicant has a Bachelor's of Science and a Master's Degree in Social Work, both granted by California State University, Fresno. Applicant has worked as a professional social worker for Madera and Tulare Counties, and spent three months as a Supervising Social Worker for Tulare Youth Services before being hired as a CSW for CDCR, where she worked for seven years, up to May 30, 2013.

18. Applicant described her work environment and job requirements in more detail than the Essential Functions description. She testified she was required to be alert, effective, and respond "all the time." She said she worked in a maximum security institution at Corcoran with Level IV prisoners, the most dangerous in the correctional system. She testified that her supervisor once told her that if she could not focus and be alert, she should not come into work. She worked four days per week, 10 hours per day, with a considerable portion, at least four hours of each workday, sitting and performing assessments, and then entering the data in computer inmate patient records.

19. Applicant's daily work duties included being required to carry alarm equipment and keys on a long, heavy chain and to push open and pull closed heavy security doors as she moved about the prison to check on whether any of the inmates assigned to her supervision were suicidal. She received a list of prisoners she was required to see each day,

and since the prison cells are on two stories, many of the prisoners she had to visit were housed up a flight of stairs on the upper tier. She was required to carry prisoner files that were dropped in the alcove to and from her office. If the inmate was a new one, the file was likely to weigh approximately 10 pounds, if a long-term or life prisoner, the file could weigh 15 or 20 pounds. She noted that most of the prisoners she was assigned to her were long-term inmates.

20. Applicant strongly expressed dissatisfaction with her work environment, its suitability for injury-free work and frustration with and anger at her supervisors for routinely ignoring her requests for improvements. She testified she repeatedly pleaded with her supervisors more ergonomically friendly for the work she was required to do. She also pleaded for help to make her work environment less prone to exacerbate problems she claimed her work produced with her wrists, hands, lower back, knees and feet. She asked her supervisors several times for an ergonomic evaluation of her office area and computer terminal where she spent much of her time at work, and never received one. She repeatedly asked for help in lifting and moving heavy files, and never received it. She was required to handwrite notes when monitoring inmate patients on the tiers or when assessing them, and then later key her notes into the computer, very hand intensive work. She asked for help that might relieve some of the repetitive stress on her hands and wrists, but received none. She acknowledged that even after she complained about lifting and carrying the files, "I could do the job," but "my hands were just hurting." After her fall down the stairs in November 2012 and her return to work in February 2013, "I told my supervisor I could not do it anymore," and "I told her I had to take Vicodin at work on my breaks in order to deal with the pain."

21. Applicant acknowledged being treated by Dr. Calhoun, who prescribed the Vicodin for her pain. She switched to Dr. Garcia through the Worker's Compensation system, and he changed her pain medication to Norco and Percocet, which she said was "better for my pain."

22. Applicant testified her last day of work was May 30, 2013, when Dr. Calhoun took her off work. She returned her computer and keys, and that was the last day she was actually present on the worksite.

23. Applicant testified she was "fired" by CDCR on August 13, 2013. She testified that CDCR sent her a letter of termination on August 9, 2013, but she does not have a copy of the letter. She claimed that she does not recall the details of the letter. She testified that CDCR Human Resources (HR) told her there is no such thing as modified or light duty with CDCR, but she was "lucky," because her supervisor gave her an informal modification of her duties such that even up to her last day of work, she was not required to go up and down stairs while working.

24. Applicant testified she hurt her back, right knee and ankle, and was off work from the time of her injury on November 20, 2012, until February 13, 2013. She returned to work on full duty, but her supervisor said that she should not be climbing the stairs, so he assigned her all downstairs patients. She testified that her legs "hurt a lot," and that she

cannot walk or sit, because her back “just kills me. She claimed she has carpal tunnel syndrome. She said she missed a lot of work because she was only able to work between four and six hours per day, because “I was in way too much pain.” She testified that after she returned to work, she “had to use FMLA hours” to modify her shifts so that she could tolerate the work, but “I just could not do it because I was in too much pain.” She claimed that the last day she was fully capable of performing her job duties was the day she was hurt, November 12, 2012.

25. Applicant acknowledged that she was in a car accident in 2011. She acknowledged she broke her left ring finger, and sustained a concussion. She testified that she missed a week of work, then returned to full duty. She failed to mention that she also sustained injuries to her lower back, knees and feet as a result of the collision, and that her injury to her feet required treatment by a podiatrist.

26. Applicant testified that currently she cannot use her hands repetitively, she cannot stand or sit for more than 15 to 20 minutes per hour without pain, and suffers from depression. She claimed she did not recall whether she had problems with her hands before she worked for the State. She started to file a Workers Compensation claim for her hands in July 2009, but “my supervisor talked me out of it because it was too much paperwork.” She claimed that because “my hands kept on hurting,” she filed another Workers Compensation claim for her hands in May 2013. She acknowledged that the claim has not been accepted, meaning it is disputed, and that dispute is currently pending.

27. Applicant testified that even when Dr. Maclean and Dr. Garcia (below) limited her work to 15 to 20 minutes per hour, she still experienced “excruciating pain,” in her low back, radiating into her legs, and her “extreme pain” continued even when she was taking Vicodin, Norco and Percocet. She acknowledged taking a variety of antidepressant medication, but they make her very drowsy and interfere with being alert. She testified that her depression set in right after she lost her job. She testified she does not sleep at night because she has continuing pain in her hands, legs, thighs and low back. She claimed to have trouble walking due to pain in her low back, legs and her feet, now must use a cane to get around. She claimed she had no back trouble before she started working for the State. She claimed that Dr. Garcia prescribed use of the cane, that she has problems walking without it, but she cannot use it at the prison, because it is prohibited.

28. Applicant filed Workers Compensation claims for injuries sustained as a result of her fall on the stairs at work on November 20, 2012. Applicant acknowledged that her Workers Compensation claim for injuries to her low back, right knee and ankle from her fall on the stairs at work on November 20, 2012, was not accepted, and she is now appealing the denial.

Applicant's Medical Evidence

29. Applicant received medical treatment, in addition to that from Dr. Torres and his NP, beginning on October 2, 2013 with Dr. Garcia, and with Dr. Calhoun between May

and October 2013. She was also treated by Dr. Flaherty for complaints of pain and tingling sensations in the bottom of her feet following prolonged standing/walking.⁹ Applicant was evaluated by MRI studies and an electrodiagnostic evaluation by Dr. Do on July 18, 2013 that included a nerve conduction and electromyography studies of applicant's lower extremities.

Dr. Garcia

30. Applicant's medical evidence was primarily founded upon two brief letters written by Dr. Garcia and his testimony in support of those letters. Dr. Garcia is Board certified in Internal Medicine with a general family practice. He has been applicant's treating physician since October 2013. Dr. Garcia submitted two letters to CalPERS, approximately a lengthy paragraph each, in support of applicant's claims, and testified briefly in support of the opinions that he expressed in the letters.

31. Dr. Garcia's first letter is dated August 8, 2014. He described applicant in this letter as "a very unfortunate lady." He wrote:

She has wrist discomfort and pain from carpal tunnel syndrome.¹⁰ She has severe degenerative disc disease of the spine and osteoarthritis affecting the hip and knee joints.¹¹ This condition produce (sic) constant pain and spasm on the joints and muscles of the lower extremities. Her mobility is also affected by plantar fasciitis and heel spurs. She can hardly walk without using (sic) cane for balance and transfer. In this regard Armida cannot perform her duties as (sic) Clinical Social Worker. Based on my physical assessment, I consider Armida permanently disabled.

32. Dr. Garcia's second letter, dated December 1, 2015, is slightly longer, and is written in response to Dr. Ha' Eri's Supplemental Report dated November 13, 2015. Dr. Garcia's second letter was not considered by CalPERS in denying the initial application, in that it had not been written at the time that decision was made. Dr. Garcia referred in his second letter to the MRI applicant had on June 9, 2014, in Mexico. Dr. Garcia stated, "The MRI showed right-sided scoliosis, focal vertebrae hemangioma at the level of L4, T 12-L1,

⁹ There are no records from Dr. Flaherty in evidence.

¹⁰ There is no diagnosis by any of the orthopedic surgeons who evaluated applicant that she has carpal tunnel syndrome, and there are no MRI or EMG studies of applicant's wrists in evidence that would support such a diagnosis.

¹¹ Dr. Garcia made no reference in the letter to any records, diagnostic tests, imaging or other medical evidence supporting this statement, nor were any of Dr. Garcia's charts or records for applicant introduced that do so.

disc degeneration without foraminal root compression.” He described vertebral hemangiomas as benign vascular tumors around one or two vertebral bodies. He wrote:

They usually occur in the lower thoracic and upper lumbar region (sic) it may cause vertebral collapse and compression fractures. They do not generally cause symptoms, but when they do back pain is the most common symptoms (sic) followed by weakness on (sic) the lower back and legs. The pain is worse at night and on awakening, it also radiates to the hips, legs and feet leading to difficulty walking and transfer. Armida also has R sided scoliosis and disc degeneration. This will cause nerve compression leading to radiculopathy and pain on the affected area. The MRI report clearly supports Armida’s complaints and symptoms.

33. Dr. Garcia testified in support of his opinions and treatment of applicant, and in support of his reports. He had seen and relied on applicant’s June 2015 MRI in Mexico. Dr. Garcia testified that he has been treating applicant for her wrists, her back, and prescribes for her pain and depression. Dr. Garcia diagnosed applicant as suffering from lumbar radiculopathy, osteoarthritis, major depression, obesity and hypertension. Dr. Garcia acknowledged that, besides applicant’s self-reports of symptoms, disability, limitations and incapacities, he largely based his opinions about applicant’s limited mobility and disability of her low back due to lumbar radiculopathy upon the July 13, 2013 electro-neurodiagnostic studies performed by Dr. Do, and upon the June 2015 Mexican MRI.

34. Dr. Garcia testified that he looked at applicant’s job description, and opined that she “cannot perform her job duties as a CSW 100 per cent of the time. He testified, “She cannot type, write, lift, carry, has no strength or agility, has limited mobility and range of motion in her hands and her lower extremities due to pain, cannot sit for any significant period of time, and cannot respond effectively to emergencies,” because the medications he prescribed and she takes diminishes her ability to focus and concentrate. He named those medications as Norco and Percocet for pain relief, and large dose Ibuprofen. He took applicant off Vicodin and changed it to Norco, which is a Tylenol and Vicodin combination, shortly after he began to treat her.

35. Dr. Garcia modestly retreated from some of his opinions on cross-examination. For example, he acknowledged that applicant can type, but for no more than 15 minutes at a session, and then she needs to rest. He testified she is in constant pain and cannot move her hands, yet acknowledged that she can type, work with files and use her hands at work for brief periods, as long as she has adequate rest. He acknowledged that his opinions regarding her disabilities and incapacities are subjective and are primarily based on applicant’s reports to him of her pain, and her inability to move and respond. He confirmed that some of his opinion was based upon his own range of motion testing during his clinical examinations of applicant. He later testified that it was “hard to say about applicant’s inability at typing, because she has pain, she can do basic typing, but it causes pain.” He also

retreated modestly from his first expressed opinion that applicant cannot sit or stand due to her pain, and acknowledged that he believes applicant can sit for up to one half of a 10 hour work shift, and that she can be on her feet or stand for 15 minute periods, but no more because, of her pain, plus the fact that she needs a cane or assistive device to support herself. He acknowledged that she can walk 10 to 15 minutes per hour, but then must rest. He first stated that she cannot bend at the waist, but then later testified that she cannot bend at the waist frequently, nor can she twist at the waist frequently. He would limit her to carrying no more than 10 pounds at any given time due to pain.

36. Dr. Garcia opined that the medications he prescribed for her ease, but “do not relieve her pain.” Dr. Garcia confirmed he has treated applicant’s pain symptoms with cortisone shots for her wrists, right knee and low back, controlled substance medications Norco and Percocet, 800 mg NSAID¹² anti-inflammatories and antidepressants such as Tramadol and Lexapro, some of which he has used off-label for his impression that applicant suffers from chronic pain. He did not mention why he prescribed both Norco and Percocet, or of the potential for adverse consequences and production of symptoms due to prolonged use of opiates.

37. Dr. Garcia, responding to a question regarding causation of applicant’s low back and foot pain, testified that applicant’s fall on the prison stairs on November 12, 2012, “could be contributory” to “causing radiating pain from her nerve root down her legs producing limited mobility and pain.” He confirmed that it is his opinion that she has degenerative osteoarthritis causing narrowing of her vertebral joints, a condition that gets progressively worse with age and wear and tear, and for this reason, applicant is “unlikely” to be able to perform her duties as a CSW into the foreseeable future.

Dr. Maclean’s Agreed Medical Examination (AME)

38. Applicant also relied upon the hearsay opinions and conclusions of Craig Maclean, M.D., a Board certified Orthopedic Surgeon, contained in his detailed report of his “orthopedic musculoskeletal” AME of applicant on November 7, 2013, produced as part of the medical evaluation of her Worker’s Compensation claims. Dr. Maclean documented applicant’s report of her workplace injury in November 2012 and its effects, as well as two additional injuries suffered by applicant in 2009 and 2012 that were not accepted as compensable workplace injuries. Dr. Maclean considered these two additional injuries as part of his overall assessment of applicant’s claims of disability and the relationship of those claims to her work.

39. Dr. Maclean noted applicant told him that she sustained swelling, stiffness, numbness and tingling in her hands and fingers on July 27, 2009, after retrieving heavy boxes of files. Applicant told Dr. Maclean that the swelling, numbness and tingling of her hands, wrists and fingers bothered her performance of usual duties such as rotetaking, typing and computer and mouse work. Dr. Maclean also noted that applicant told him that after she

¹² Non-steroidal anti-inflammatory drugs.

became represented for her injuries suffered when she fell down the stairs at work on November 20, 2012, she saw Dr. Mangat for the bilateral numbness and tingling in both her wrists, more on her left side, that she claimed she began to experience in 2009 after lifting heavy charts and boxes at work, and typing at her desk.

40. Dr. Maclean noted in his AME report that he read Dr. Mangat's May 30, 2013 Doctor's First Report of Injury (First Report), regarding applicant's wrist complaints, and found that Dr. Mangat mentioned in that report as significant the fact that applicant was involved in a car accident on June 2, 2011, when she was stopped at a red light and a small truck hit her vehicle from the side. Dr. Maclean noted that Dr. Mangat found important that applicant sustained injuries to her neck, both shoulders, low back, and evidently fractured her left ring finger as a result of the collision.

41. Dr. Maclean reviewed applicant's medical records, including his review and summary of Dr. Mangat's First Report, dated May 10, 2013, in his AME. Dr. Maclean noted that Dr. Mangat concluded in his report, regarding applicant's complaints of bilateral chronic arm pain, forearm pain, wrist joint pain, hand pain, and numbness and tingling that:

I do not think that her ongoing bilateral arm pain and numbness and tingling is specifically related to her work and that she will continue care with her PCP. I base this opinion on that she had a motor vehicle accident with neck, shoulder and back in July and her vague pain complaints of numbness and tingling in both arms seem to be related to neck injury from that accident.

42. Dr. Maclean also noted a May 29, 2013, request letter from Dr. Calhoun, requesting a "consult for the NESP-R program for chronic pain patient that includes narcotic detoxification."

43. Dr. Maclean reviewed a January 30, 2013, report from an MRI of applicant's knee and noted the MRI report was negative for any injury or abnormality. An earlier additional MRI of applicant's knee showed some early and beginning signs of osteoarthritis, but was otherwise negative. He noted applicant's treating doctor at the time at the Visalia Medical Clinic, Dr. Torres, ordered applicant to continue with physical therapy, and return to work on modified duty, with no kneeling or squatting, and limited climbing of stairs or ladders.

44. Dr. Maclean noted that applicant returned to see Dr. Torres at the Visalia Medical Clinic on February 27, 2013, and that she was placed back to full duty at work on February 11, 2013, due to the negative MRI findings mentioned above. Dr. Maclean observed that the chart note of applicant's office visit, attended by Dr. Torres' nurse practitioner that same day, reflect that applicant told the nurse practitioner she had returned to work for three days on modified duty, and told her that she was taking Vicodin between shifts in order to be able to work, and complained that she could not return to work because of the extreme amount of pain she was experiencing, complaining not only of knee pain

radiating from the knees up into her lower back, but also burning pain on the bottom of her feet. Dr. Maclean noted that the nurse practitioner reported, "Patient requests to be placed on disability," and when the nurse practitioner told her she could not do that, applicant requested to see the doctor.

45. Dr. Maclean also noted that applicant returned to see Dr. Torres on February 28, 2013, continuing to seek his approval to put her on permanent disability. Dr. Maclean noted that Dr. Torres wrote that applicant also told Dr. Torres that the bottom of her feet were hurting after the car accident on June 2, 2011, and that she went to see Dr. Flaherty, a podiatrist, who told her she had plantar fasciitis, and gave her some cortisone shots in her feet about six months ago. Dr. Maclean noted that Dr. Torres did not give applicant the permanent disability she sought, and that he diagnosed arthralgias and back pain, and concluded she was medically fit to continue to return to work on modified duty with limitations, including no kneeling, squatting, or climbing stairs or ladders, through March 15, 2013.

46. Dr. Maclean noted that Dr. Torres' chart note of May 14, 2013, notes that even though applicant complained of a pain level of 7.5 out of 10, she told Dr. Torres that therapy helped "quite a bit" and that "she feels she wants to go back to work now." She was found medically fit to return to work on full duty, but she should see her primary care doctor for elevated blood pressure and for her obesity. There is no evidence she did so.

47. Dr. Maclean noted that applicant switched primary treating physicians just after Dr. Torres found her medically able to return to work on May 15, 2013, to Kevin Calhoun, M.D. and Russell Dunham, M.D., doing business as WorkMed. Dr. Maclean noted that Dr. Calhoun diagnosed cervicalgia (neck pain); lumbago (pain in the lumbar spine); lumbar radiculitis/neuritis (NOS); and bilateral shoulder impingement syndrome. Dr. Maclean noted Dr. Calhoun made several requests for tests and additional treatment at the time of his initial assessment and acceptance of applicant as a patient.

48. Dr. Maclean noted that applicant underwent electromyography (EMG) and nerve conduction studies of her lower extremities performed by Dr. Do on July 18, 2013. He noted Dr. Do concluded that the nerve conduction study was normal, and the electromyography was abnormal, suggesting of bilateral chronic active L5 radiculopathy.¹³

49. Dr. Maclean also noted that applicant complained that her claimed industrial injuries have impacted her activities of daily living. She complained that she had problems with self-care, which she described as personal hygiene, trouble brushing her teeth, cutting her food, washing and drying herself, writing a note, typing a message on a computer, along with walking outdoors on uneven ground or when trying to climb up one flight of 10 steps. She complained that opening car doors, twisting off bottle caps, and turning faucets on and

¹³ Radiculopathy is radiating pain, numbness and/or tingling into an extremity caused by an injury to a nerve.

off were “extremely difficult.” She also complained of difficulty sleeping, commenting that she wakes up several times a night due to pain in her back and legs.

50. Dr. Maclean conducted an orthopedic musculoskeletal physical and neurological examination as part of his AME. He described applicant as “heavyset,” in no apparent acute distress, 5’4” tall weighing 250 pounds. He found no evidence of motor or sensory deficits in applicant’s upper or lower extremities. He found some reduction in range of motion in the thoracic and lumbar spine, with palpable lumbar paraspinal muscle spasm. He found full range of motion in applicant’s head and neck, as well as in both of her upper extremities, including both shoulders, both elbows and forearms wrists and hands.

Dr. Maclean’s AME Findings and Conclusions

51. Dr. Maclean diagnosed that applicant had sustained: 1. Contusion with chronic strain of right knee and right ankle; 2. Repetitive strain injury to bilateral wrists and hands; and 3. History of psoriasis; rule out systemic inflammatory process.

52. Dr. Maclean concluded that applicant experienced periods of temporary disability as a result of injury to her hands, wrists and fingers as a result of repetitive stress between July 27, 2009 and May 30, 2013, and injury to her right ankle and foot due to her fall at work on November 20, 2012. Dr. Maclean concluded that the injuries to applicant’s upper extremities were five percent non-industrial, caused by the motor vehicle accident on June 2, 2011, and the rest caused by work, and that the injuries to her lower extremities were five percent non-industrial, caused by her morbid obesity, with the rest due to the fall down the stairs at work. Dr. Maclean ordered work restriction for applicant’s upper extremities of no repetitive grasping, pushing or pulling of objects requiring more than 25 pounds of force; and for her lower extremities, no repetitive climbing. He recommended consideration of additional medical care, based on receipt of an internal medicine consultation and right knee and ankle x-rays.

53. Dr. Maclean and Dr. Mangat did not testify. Their opinions and conclusions, expressed in Dr. Maclean’s AME report dated November 7, 2013 and Dr. Mangat’s first report of May 10, 2013, are hearsay.¹⁴

Electro-Neurodiagnostic Studies-Dr. Do

54. Dr. Do conducted an electro-neurodiagnostic study on applicant on July 18, 2013. Dr. Do’s study included electromyography (EMG) and nerve conduction studies. Dr. Maclean, Dr. Garcia and Dr. Ha’Eri each referred to this study in one fashion or another in their reports. Dr. Do’s nerve conduction studies included sensory nerve testing and motor nerve testing of applicant’s lower extremities. Dr. Do’s conclusion was that the EMG sensory and motor nerve testing study was normal, but the electromyography was abnormal,

¹⁴ Government Code section 11513, subdivision (c).

“suggestive of chronic active L5 radiculopathy, right side greater than left side.” Dr. Do’s report of his electromyography study states:

Using monopolar disposable needles, the muscles of the bilateral lower extremities were examined. With the muscles at rest upon needle insertion, there was an absence of fasciculations, fibrillations and positive sharp waves. Upon submaximal contraction, the motor units were of normal size, shape and amplitude except for the presence of one plus polyphasic potential and one plus giant wave potential found in the bilateral petronius longus muscles, right side greater than left side.

55. Dr. Do’s report contains a list of the muscles that he sampled in performing his electromyographic study of applicant’s lower extremities. Dr. Do’s list of muscle sampled appears printed in his report just above the “Findings on Examination” quoted above. Dr. Do’s list of muscle sampled identifies 11 muscles or muscle groups that he sampled. The list of muscles or muscle groups sampled does not include petronius longus, bilateral or otherwise.

Dr. Ha’eri’s IME

56. Dr. Ha’Eri conducted his orthopedic IME of applicant on April 5, 2014. Dr. Ha’Eri reviewed the Essential Functions and Physical Requirements descriptions for a CSW, and applicant’s medical records, and diagnostic testing and studies before conducting the examination. Dr. Ha’Eri had applicant complete a comprehensive questionnaire before the examination began, in which he asked applicant to describe the history of her injury, what injuries she sustained, what symptoms she experiences, her current complaints, her current treatment, her personal, social and medical history, and her description of her job duties, particularly those she felt she could no longer perform.

57. Applicant wrote on Dr. Ha’Eri’s questionnaire that her fall down the stairs at work on November 20, 2012, resulted in pain in both legs, including her right knee and her feet.¹⁵ She reported her treatment with Dr. Garcia and receipt of cortisone shots for pain in

¹⁵ Dr. Maclean did not diagnose any problem with applicant’s feet nor any correlation between her claims of pain in her feet to her fall in his AME evaluation. He evidently embraced Dr. Mangat’s opinion that any foot complaints were the product of applicant’s auto collision injuries in 2011. Applicant saw Dr. Flaherty, a podiatrist, in mid-2013 for her complaints of bilateral foot pain. Dr. Flaherty’s report and medical records are not included in the evidence, but evidently Dr. Ha’Eri saw a report from Dr. Flaherty and noted that her opinion was that applicant had bilateral plantar fasciitis and neuropathy in her feet. There was no evidence that applicant’s fall down the stairs at work in November 2012 caused applicant’s plantar fasciitis or foot neuropathy. Dr. Garcia and Dr. Calhoun both picked up Dr. Flaherty’s diagnosis regarding applicant’s foot problems, but neither opined that

her wrists, right hand low back, and the medications she was taking as prescribed by Dr. Garcia. She described her current complaints of “shooting pain going upward” in her lower back, but also she complained she could feel pain going down into her legs. She also reported pain in both hands, especially the right, “very swollen and hurting a lot, I can barely grab the pen.” She wrote, “It is very hard for me to walk without severe pain-burning sensation on both feet.” She acknowledged past medical history for hypertension, kidney disease, psoriasis, obesity and arthritis, and also reported she had been experiencing some chest pains. Applicant wrote in her job description that she is required to stand, sit, squat, climb stairs, push, pull, stoop, bend, twist, reach for records, and do, “a lot of walking from different buildings on uneven ground inside the prison.” She also wrote, “We do a lot of computer input since all notes must be typed.”

58. Applicant did not complete the portions of Dr. Ha’Eri’s questionnaire entitled “General Pain Index Questionnaire,” nor did she make any mark on the following page, which contained an outline of front and rear of a whole body where a respondent can mark the location and nature of pain and symptoms the respondent is experiencing.

59. Dr. Ha’Eri conducted a comprehensive orthopedic musculoskeletal clinical examination. He noted that applicant wore a lumbar brace and used a cane to assist with walking when she arrived at the examination. He found applicant’s range of movement in her lumbar spine was limited. He found applicant’s range of motion in her right knee, right ankle and lower extremities were normal. His neurological examination of all applicant’s extremities, including applicant’s hands and wrists, were normal for sensation and motor function.

60. Dr. Ha’Eri concluded in his initial IME report dated April 5, 2014, that there were specific job duties that he felt applicant was unable to perform at the time of his examination due to applicant’s physical condition. He wrote:

She is unable to sit constantly for over six hours, frequently lift/carry 26 to 50 pounds, and occasionally bend-stoop because of her low back condition. She is unable to use the mouse and keyboard frequently due to the condition of her wrists (flexor tenosynovitis).¹⁶

Dr. Ha’Eri concluded the following:

It is my professional opinion that the member is presently substantially incapacitated for the performance of her duties as a CSW at CSP Corcoran. Her disability began on May 29, 2013.

applicant’s plantar fasciitis, heel bone spurs or foot neuropathy were caused or exacerbated by her fall down the stairs at work in November 2012.

¹⁶ Soreness caused by inflammation in the synovium of the flexor tendons of the hand.

Her inability to work at her position is due to the condition of her lower back and bilateral wrists.

At this time, I find the claimant temporarily presently substantially incapacitated from the performance of her usual occupation as a CSW for a duration of less than six months. In my medical opinion, the claimant would benefit from an MRI of the lumbar spine to better determine the cause of her incapacity.

The claimant's current temporary disability is due to nonindustrial conditions of her lower back and bilateral wrists. The present condition of her lower back, with radicular symptoms in the lower extremities, as well as her bilateral wrist pain are not caused, aggravated or accelerated by her employment. These conditions would have been present if the member had not been employed in this job.

DR. HA' ERI'S SUPPLEMENTAL IME REPORTS

61. Dr. Ha'Eri issued a Supplemental IME Report on May 24, 2014. Dr. Ha'Eri noted that he was asked to respond to a Residual Functional Capacity Questionnaire completed by Dr. Garcia, in which Dr. Garcia stated that applicant was suffering from "severe bilateral hip and bilateral knee osteoarthritis." Dr. Ha'Eri noted that he reviewed diagnostic studies, including x-rays by Dr. Smith taken January 23, 2013, showing no abnormality of the knees, and an MRI, also obtained by Dr. Smith on January 30, 2013, of applicant's right knee, showing a normal right knee. Dr. Ha'Eri expressed his opinion that Dr. Garcia's opinion and diagnosis was not correct in regard to applicant's knees. Dr. Ha'Eri deferred on any conclusions regarding applicant's hips or lumbar spine, as there is no MRI study or x-rays available for him to review of applicant's lumbar spine or hips.

62. Dr. Ha'Eri re-reviewed all of the available medical records and his own findings on orthopedic musculoskeletal physical examination, and made a revised diagnosis as follows:

- (1) Lumbar strain;
- (2) Right ankle sprain, resolved;
- (3) Right knee sprain, resolved; and
- (4) Possible bilateral wrist/hand flex or tenosynovitis, mild.

63. Dr. Ha'Eri opined in his Supplemental IME report that there are no specific job duties described in applicant's Essential Functions or Physical Requirements descriptions, or her own descriptions of her job activities she told him about during his clinical interview that she cannot perform because of a physical or mental condition. He stated, "It is my professional opinion that the member is not presently substantially incapacitated from the performance of her duties as a Clinical Social Worker at the

California State Prison, Corcoran. He concluded by stating, in response to a question of whether any part of applicant's disability was due to nonindustrial or pre-existing conditions, "Not applicable. Claimant has no disability."

64. Dr. Ha'Eri issued a Second Supplemental IME Report, dated November 7, 2015, after being provided a translation of the MRI of applicant's spine performed on June 9, 2014, by the physician in Mexico. He noted the MRI found, "right-side scoliosis, focal vertebral hemangioma at L4, T12-L1, space normal: disc degeneration without foraminal nerve root compression." Dr. Ha'Eri opined that the results of the MRI were "unremarkable," and:

It is my opinion that there are no specific job duties that I feel this member is unable to perform because of her physical condition. Therefore she is capable of returning to her regular occupation performing her regular duties without limitation.

DR. HA' ERI'S TESTIMONY

65. Dr. Ha'Eri testified in support of his IME and Supplemental IME Reports. Dr. Ha'Eri is Board-certified in Orthopedic Surgery in the United States, United Kingdom (UK), Scotland and Canada, and earned a postdoctoral Master's Degree in Orthopedic Surgery in Liverpool, UK, in 1979 and a Ph.D. at the University of Toronto, Canada in 1987. Dr. Ha'Eri maintains an active clinical and orthopedic surgery practice, seeing as many as 30 to 40 patients per day and performs approximately 10 to 12 orthopedic surgeries per month, presently limited to surgeries for problems related to hips, knees, hands, and elbows. Dr. Ha'Eri has not performed spinal surgery for the most recent two years, but did so for the previous 30 consecutive years of his clinical and surgical practice. Only a tiny fraction of Dr. Ha'Eri's current practice consists of performing Worker's Compensation QMEs, and even smaller percentage, only in the most recent two years, of performing IMEs for CalPERS.

66. Dr. Ha'Eri's opinions and conclusions were based not only on his orthopedic musculoskeletal clinical and physical examination of applicant, but also upon his review of the MRIs, particularly of applicant's knees and most recently the MRI from Mexico of her mid back area, the EMG and the x-ray studies of applicant's knees and ankles.

67. Dr. Ha'Eri explained his first IME opinions about incapacity and work limitations for applicant were the result of the fact that it was his first CalPERS Evaluation. He admitted he made a mistake because he was not familiar with the CalPERS standards and criteria for substantial incapacity, or how much different those standards were than the standards ordinarily applied in a Workers Compensation evaluation. His previous experience in performing evaluations was all for Worker's Compensation, where he seeks to identify prophylactic restrictions, and suggest additional testing or remedies and measures in order to remediate and rehabilitate conditions and problems identified. He pointed out the standard for evaluation is considerably more relaxed in a Worker's Compensation evaluation versus a

CalPERS evaluation, and in the Worker's Compensation evaluation there is much more "guessing and estimating" in order to determine appropriate prophylactic limitations. Dr. Ha'Eri pointed out that he used Worker's Compensation standards in evaluating applicant in his first IME, and that is why he made some limitations findings, but he pointed out that these were both temporary, and none of these conditions identified or limitations suggested were caused or exacerbated by her work. Dr. Ha'Eri pointed out that the work restrictions he suggested as a part of his first IME report were intended to be very short-term, as he saw no evidence in his evaluation that applicant had sustained any sort of permanently incapacitating injury, that there existed an absence of evidence that any injury, limitation, disability or incapacity she claimed were caused by her work, and none of the medical records and diagnostic studies that he saw gave any such indication.

68. Dr. Ha'Eri noted that in his physical examination of applicant's hands, she had full range of motion, with no locking of her fingers, and no "trigger finger." He noted that she was able to make a full fist, and there was no sign of any atrophy, wasting or swelling, all of which he expected to find if applicant had carpal tunnel syndrome, or some other encroachment of the median nerve in her wrists. He conducted grip strength testing with a Jaymar Dynamometer, recording stronger readings of 20/20/20 on applicant's dominant right hand, and lesser on her left hand of 15/15/15 on three squeezes each. He performed provocative wrist testing using Tinel's, Phelan's and Finkelstein's tests to determine whether there was evidence of carpal tunnel syndrome present. He found none of the tests produced a positive result. He also pointed out that there are no MRI or EMG studies of applicant's wrists, which are required in order to move any diagnosis away from a purely self-reported subjective complaint, and determine whether there is any objective orthopedic evidence present to support those claims of pain and disability.

69. Dr. Ha'Eri's range of motion testing for applicant lower back showed limited range of motion in her lumbar spine. He pointed out that range of motion testing is very subjective, in that the examinee's response to the instruction to move during the examination is entirely voluntary, and thus is limited to what the patient can and is willing to do. He also noted that not everyone's range of motion is the same due to how "the body's habitus" affects it, pointing out that his personal range of motion in his back is somewhat restricted because he has a "big tummy." He found that applicant has about half of the normal range of motion in her lumbar spine, but that her morbid obesity definitely limits her range of motion. He also noted that limited range of motion by itself is not sufficient information to support an opinion or a diagnosis. He pointed out those objective findings that a patient cannot control, such as imaging, x-rays, and MRI of the lumbar spine and/or EMG, and ideally all of these, are necessary to support an orthopedic diagnosis. He was critical of an EMG alone as a basis for diagnosis, in that "interpretation of an EMG is rather subjective," and that "an MRI is a far better assessment tool" for supporting an orthopedic diagnosis.

70. Dr. Ha'Eri testified that on his neurological examination of applicant's lower extremities, he could not find any neurological deficit, concluding that his examination of

applicant's lower extremities was "grossly normal."¹⁷ He pointed out that performing a straight leg raise stretches the sciatic nerve in a fashion that ordinarily produces pain and discomfort if the sciatic nerve is adversely impacted by an orthopedic disability such as a bulging disc. He also expected to see pain and spasm changing the curvature of the normal lumbar lordosis in applicant's low back, if she had suffered an orthopedic injury such as a ruptured or bulging disc in her lower spine. He found only mild lower lumbar/sacral tenderness, and normal sensation to touch, pinprick, and with her reflexes. He observed that she had a normal lumbar lordosis, without any evidence of spasm, and no more than mild tenderness to sensory testing, indicative of a lack of lumbar orthopedic injury or disability. He pointed out that absent evidence of a lower lumbar orthopedic injury, claims of bilateral radiculopathy and pain into the legs have no orthopedic medical support.

71. Dr. Ha'Eri's diagnosis was that applicant had a temporary sprain/strain injury to her low back, right knee and ankle that should have resolved in the more than one year between the time she stopped working in May 2013, and the time that he saw her for the IME. He pointed out that applicant's strain to her low back, right knee and right ankle as a result of her fall on the stairs in November 2012, should have been treated conservatively, and in the year that has passed since she stopped working, the inflammation should have subsided. He testified that since there was no MRI of applicant's lumbar spine, perhaps she had a disc problem, but there was no way to know. Such a disc problem could possibly be the source of the claimed bilateral lower extremity radiculopathy, but again there was no way to know without objective testing, and all previous opinions claiming the bilateral lower extremity radiculopathy were based almost exclusively upon applicant's subjective self-reporting. He pointed out there is no objective clinical evidence of upper extremity problems with her hands and wrists other than some flexor tenosynovitis, which is not disabling.

72. Dr. Ha'Eri testified that there is "no osteoarthritis in applicant's knees, period." He pointed out that in his clinical physical examination of applicant's lower extremities, he found a "non-symptomatic right knee and ankle," stable to manipulation, without swelling. He noted that there are three imaging studies of applicant's knees and ankles, and MRI and x-rays, none of which show any osteoarthritis.

73. Dr. Ha'Eri testified that he found some suggestion of mild bilateral plantar fasciitis, a condition that is exacerbated by prolonged standing or walking. He pointed out that morbid obesity is a substantial contributor to creating and exacerbating plantar fasciitis.

74. Dr. Ha'Eri pointed out that the MRI taken in Mexico in 2014, upon which Dr. Garcia placed so much reliance in his second letter, was not a lumbar view at all, but rather was thoracic and upper lumbar, viewing the mid back and ribs area. He observed that none of the vertebrae in the area described in that MRI have nerve roots that would produce radiculopathy down the legs, but rather he would have expected reports of pain in the middle and lower rib cage area. He noted that pain down the legs is produced by nerve roots emerging from the vertebra in the lower lumbar region, L5-S1. There is no MRI in evidence

¹⁷ Meaning he found no evidence of foot neuropathy.

evaluating the L5-S1 area of applicant's low back. He pointed out that an MRI of this L5-S1 region was the additional testing that he was referring to as something he would like to obtain and review in his first IME report. On cross-examination he testified,

No, I do not agree that she has bilateral L5 radiculopathy, my clinical examination does not show it, and the electrodiagnostic study does not show it on examination. The Mexican MRI shows T-12 mid-back, which should result in complaints of mid-rib pain.

75. Dr. Ha'Eri continued on cross-examination by pointing out that he did not recommend that applicant use a cane for mobility. He was quite critical of Dr. Garcia prescribing Percocet for applicant, particularly over a prolonged period of time. He testified that Percocet is addictive and causes serious adverse effects on a patient's cognition and concentration, and may well be the source of many of applicant's continuing complaints. He pointed out that Dr. Calhoun made a chart note in which he pointed out the problem of applicant's evident addiction to pain medication and recommended detoxification in May 2013, yet Dr. Garcia continued Vicodin in the form of Norco and added another opiate, Percocet, which he has continued for her. He said, "I really disagree with family practice treatment of these orthopedic claims" as potentially quite harmful to the patient. He was also quite critical of Dr. Garcia giving applicant trigger point injections in her wrists for complaints of pain as "a gimmick," one that can cause the patient serious and permanent harm, and even kill the patient's median nerve when administered by a generalist, due to the exceeding difficulty of placing the needle correctly in a nerve and vessel dense area such as the carpal tunnel. He testified that even as a highly trained orthopedic specialist, he does not and would not give trigger point injections in a patient's wrists due to the very high and unacceptable risk of causing permanent harm to the patient's median nerve. He pointed out that a generalist who is daily "treating constipation and sore throats has no business sticking needles in a patient's wrists or prescribing Percocet over a long period of time for a patient such as applicant."

Rebuttal and Relative Credibility

76. Dr. Ha'Eri's testimony, although delivered in a rather matter-of-fact, disarmingly dispassionate fashion, provoked a stunning response from applicant. Applicant testified on "rebuttal" that Dr. Ha'Eri spent "only five minutes examining me; he asked me what I did, did no tests, did not use a dynamometer, did no palpation, and performed no physical examination of me." She admitted she filled out his patient questionnaire, but denied any interaction with his nurse, and denied having any vital signs taken; no blood pressure, no height no weight. She claimed Dr. Ha'Eri showed her the job description, and asked her, "Is this what you do?" She replied, "Yes," and that "he asked no other questions."

77. Applicant testified a bit later that Dr. Ha'Eri did discuss with her the fall on the stairs at work, asked her about her back pain, and asked her what was wrong with her, to which she replied by pointing out her legs. She then claimed, "We did not go into big details

about anything.” She claimed she “did not tell them about my medications” and did not recall telling him about her auto 2011 accident. Her meeting with Dr. Ha’Eri “was very, very brief” and she told her boyfriend, who she said was very surprised that she was finished so quickly. Applicant testified that Dr. Ha’Eri said, “I have the files, thanks for coming.”

78. Applicant was asked whether she had ever contacted anyone at CalPERS or reported her claim to anyone that Dr. Ha’Eri only spent five minutes with her, that he did not perform any clinical or physical examination at her IME, especially after she received his IME report. She admitted she did not contact anyone, and stated, “I did not know there was a problem; we were out of there in five minutes.”

Surrebuttal

79. Dr. Ha’Eri was recalled to respond to applicant’s surprise accusations that:

- a. He conducted a comprehensive clinical interview in which he asked applicant a number of questions about her job, her current complaints, etc.;
- b. Had his nurse obtain and record vital signs;
- c. Conducted a comprehensive orthopedic musculoskeletal physical examination in which he conducted various tests, palpated her low back and knees, and obtained physical measurements, including using the Jaymar instrument to measure applicant’s grip;
- d. Made diagnoses and expressed medical opinions in his IME report, based upon that clinical interview and upon his findings made during the orthopedic physical examination he said he conducted and applicant claimed never occurred; and
- e. Then perjured himself by testifying falsely under oath that he did or supervised the doing all of the above during his IME.

80. Applicant’s testimony appeared to visibly shock and completely surprise Dr. Ha’Eri. There was no previous notice or indication to anyone involved in the evidentiary hearing, except perhaps her counsel, that applicant had the concerns she expressed, or that she intended to make the allegations she expressed in her rebuttal testimony.

81. Dr. Ha’Eri’s reply to the accusations was as dispassionate and matter-of-fact as was his earlier testimony, despite the fact that it was visibly evident that he was deeply offended. Dr. Ha’Eri was recalled and he produced what was marked as Exhibit 15, consisting of three pages of his handwritten notes containing applicant’s personal information, her vital signs and measurements, applicant’s responses to his clinical interview questioning, his examination protocol and findings he made during his orthopedic physical examination of applicant. The notes also attached nine additional pages of his patient questionnaire that applicant acknowledged she completed, with the exception of pages eight and nine, which are blank.

82. Dr. Ha'Eri's handwritten notes are comprehensive, detailed, well-organized and although densely packed on the three pages, relatively easy to read and follow through his protocol for conduct of the IME examination. The first page, entitled "Vitals Form," contains entries for vital signs and measurements, such as height and weight, are handwritten in a hand not applicant's or Dr. Ha' Eri's into preprinted blanks at the top portion of the page. Applicant's handwriting is contained on the first seven pages of the patient questionnaire. The remainder of the document consists of three handwritten sentences in Dr. Ha'Eri's handwriting in which applicant's current complaints are written out, such as "cannot use mouse and typing due to bilateral wrist pain, cannot walk a distance due to burning pain on bottom of feet, and unable to sit long due to l. b. pain." Dr. Ha'Eri's handwritten notes continue beneath the current complaints notes and include, among other things, a handwritten note that applicant told him she suffers from kidney disease, a note regarding a "MVA" (motor vehicle accident) of 6/2/11, noting left ring finger "fx", notes that she does not smoke or drink is single has "4 kids" and is allergic to aspirin.

83. The second page of Dr. Ha'Eri's handwritten notes list applicant's medical records with date notations for each time she saw each treating physician, and dates upon which diagnostic studies and test results were obtained.

84. The third page of Dr. Ha'Eri's handwritten notes are made on a preprinted form with letterhead, with his name and information at the top, and entitled "Orthopedic Consultation." The form has preprinted headings for, among other things, Patient's Name, Date of Injury, Chief Complaint, History of Present illness/injury, "Physical Exam," "Test," Diagnosis, Recommendation, Prognosis, Disposition and a place for his signature. Next to each of the preprinted headings are large open spaces that are filled with handwritten notes. Information such as "Corcoran State Prison, Occupation: Clinical Social Worker since 2008, right-handed, applicant's height and weight,¹⁸ date of examination, applicant's birth date, date of injury, and patient's age, some of which is written in preprinted spaces, and some of which is written randomly in open spaces across the top of the document. Under "Chief Complaint" is written, in abbreviated form, that applicant's chief complaint was 1.-Bilateral wrist pain right greater than left (volar), 2.-Lower back pain with an arrow indicating radiating to her legs, and 3.-Tenderness knees. A brief history of the accident, again in abbreviated form, and her immediate treatment at Visalia Occupational Medical Clinic with Dr. Torres and his nurse practitioner is noted, as well as a note that she has not worked since 5/29/2013, and is under the care of Drs. Calhoun and Garcia, her PCP. Under the heading "Physical Exam," handwritten notes indicate that applicant was "wearing back brace, uses a cane," had lumbosacral tenderness with decreased range of motion, no PV spasm, lordotic arch checked normal and so forth. The notes are quite extensive. In the lower right third quadrant of the notes there appears "JAMAR,"¹⁹ with the letter "R" circled, the note "20/20/20," and the letter "L" circled, with the note "15/15/15."

¹⁸ This note states applicant's "HT 5'3", WT 244 lbs."

¹⁹ The misspelling is in the original.

85. Dr. Ha'Eri took the occasion of being recalled to respond to these allegations to point out that even though applicant filled out only part of his preexamination questionnaire, Dr. Ha'Eri always walks through the form question by question with the examinee because he is concerned that the examinee may not fully answer the question, may not accurately answer the question, or may provide additional data through prompting, and that he followed that practice in this examination, as reflected by his notes. He pointed out that just his notes of his orthopedic physical examination reflect work and discussion that could not possibly have been completed in five minutes.

86. Dr. Ha'Eri's handwritten notes fully corroborate his testimony, and constitute detailed and compelling documentation of the time Dr. Ha'Eri spent, the things he did, and the detail he invested in his IME examination. Dr. Ha'Eri's comprehensiveness and the detail evident in his handwritten notes of his clinical interview and orthopedic physical examination strongly support his rebuttal testimony that there was "no way I could have done all of this in five minutes."

Sur-Sur Rebuttal Claim

87. Dr. Ha'Eri's production of his handwritten clinical interview and orthopedic physical examination notes of his IME produced in response a claim even more shocking and provocative than the first; that Dr. Ha'Eri had fabricated the data contained in his handwritten notes by copying the information in his notes from applicant's medical records he already had received. Had the notes not strongly corroborated Dr. Ha'Eri's testimony regarding the fact that he actually conducted a comprehensive clinical interview and orthopedic physical examination of applicant, they would have been ignored or disregarded. There would be no reason to make the allegation his clinical notes were a fabrication, had those notes proved to be unresponsive of his testimony.

88. The allegation Dr. Ha'Eri copied his handwritten notes from applicant's existing medical records was completely unsubstantiated and wholly without foundation. No supporting evidence of any sort was identified and offered to support the claim. No specific entry on Dr. Ha'Eri's handwritten notes was identified as copied from any specific entries in any of applicant's medical records. There are many such entries in the handwritten notes that specifically rebut the claim, not the least of which is a height and weight measurement for applicant that is different than those in other records, such as Dr. Maclean's, who records her at 5'4" tall and weighing 250 pounds. The accusations were internally inconsistent, completely lacking in any evidentiary foundation and thus wholly without merit.

89. Dr. Ha'Eri had his notes in his possession in his file the entire time he was present for his testimony, and he never left the room after applicant made her allegations. He produced those notes from his file after applicant made her allegations, and they were offered in evidence. There was no opportunity for Dr. Ha'Eri to create, edit or falsify any notes in response to her surprise allegations in her rebuttal testimony.

90. Dr. Ha'Eri testified that he wrote in his first IME report that applicant put forth a good effort in testing, and was not malingering or attempting to purposely produce poor test results in his clinical orthopedic physical examination. Yet his testimony strongly and continuously suggested that applicant's complaints of pain, disability, inability to perform work tasks, and incapacity were grossly overstated and are wholly unsupported by any orthopedically reliable medical, diagnostic or clinical findings or evidence. He repeatedly pointed out that a large part of any discomfort or disability applicant was experiencing was caused by her morbid obesity and addiction to opiate pain medications first pointed out by Dr. Calhoun in May 2013. He pointed out her medical records repeatedly documented reluctance to undertake a program to reduce her body mass and the excess stress caused by her morbid obesity upon her joints, particularly her feet, significantly exacerbating her problems with her low back, lower extremity joints, and particularly inflaming the plantar fasciitis in her feet. The warning by Dr. Calhoun about continuing to take opiates for pain was evidently ignored. The clear import of this testimony was that applicant was the primary responsible author of most of her own complained of pain and discomfort by failing to keep her body mass under reasonable control, and failing to wean off opiate pain medications. The implication was that applicant's complaints of pain, disability and incapacity were greatly exaggerated in nature and histrionically presented, rather than the product of any work-related injury or condition.

91. Applicant's angry outbursts were not mentioned, apologized for, or excused in her written closing arguments. Applicant's outbursts appeared to be a direct retaliatory response to Dr. Ha'Eri's intense and focused recitation of the medical reasons why applicant is not orthopedically disabled, that her complaints are not work-related and that she should never have been prescribed or allowed to continue taking Percocet for her constellation of reported medical problems by Dr. Garcia. Regardless of the genesis of her frustration, applicant chose to use the occasion of her testimony under oath to make unsubstantiated and reckless claims of misconduct directed at Dr. Ha'Eri, and in so doing, did grave and irreparable harm to her credibility. Applicant's overly dramatic, histrionic and hypochondriac presentation of herself throughout the evidentiary hearing further harmed her credibility.

92. Applicant's poor credibility had the collateral effect of fatally damaging any persuasiveness that her subjective self-reports of pain, symptoms, disability and incapacity might have had in supporting her claims. Applicant's initial treatment after her fall in November 2012 through March 2013 with Dr. Torres and his nurse practitioner at Visalia Occupational Medical Clinic was very much in line diagnostically and clinically with Dr. Ha'Eri's opinions. Applicant switched to Dr. Calhoun and ultimately Dr. Garcia when she decided she could not cope with Dr. Torres's order to return to work on full duty in late February 2013, and when she returned to appeal to him to take her off work and find her totally and permanently disabled, he declined. Dr. Ha'Eri's implicit suggestion in his testimony that applicant began treating with Dr. Calhoun and ultimately Dr. Garcia reflected applicant's not necessarily seeking medical treatment directed toward helping her get better, recover function, and return to work, but rather favorable medical opinion supportive of her desire to be found medically disabled, as she specifically told Dr. Torres' nurse practitioner

in February 2013. Dr. Ha'Eri's implication that applicant is and has been motivated to appear more disabled and incapacitated than the objective orthopedic medical evidence can confirm has substantive evidentiary support in this record besides just Dr. Ha'Eri's impression.

Work Restrictions and Substantial Incapacity

93. Applicant points to the fact that work restrictions were imposed by Dr. Garcia, Dr. Maclean, and even Dr. Ha'Eri in his first IME report, as evidence she is permanently incapacitated and unable to return to work. Dr. Ha'Eri dispensed with this claim rather succinctly, pointing out that any work restrictions or limitations he suggested were prophylactic in nature, did not impact the great majority of the work requirements as set forth in the essential functions and physical requirements to descriptions, and were temporary in nature because applicant's injuries were all of the sprain/strain variety that should have healed with conservative treatment fully and completely, particularly during the year between the time she last worked and the time he saw her for the IME. He pointed out persuasively that if applicant continues to have disability or incapacity or work limitations required, those were all the product of nonindustrial, non-work-related problems such as her morbid obesity and opiate dependency.

94. Dr. Ha'Eri used the occasion in his testimony when asked to explain the mistake he made by using Worker's Compensation standards, rather than CalPERS-Government Code-*Mansperger* (below) disability retirement standards to impose prophylactic work restrictions in his original IME as an occasion to elaborate on the difference between the two. He made it quite clear that he considered applicant's limitations at the time he saw her to be temporary in nature, not industrial in causation, and conditions that she should be able to recover from and return to work after a period of time in which some of her activities should be limited in order to assist in her recovery.

Analysis of The Relative Persuasiveness of The Medical Evidence And Evidence of Incapacity

95. Dr. Ha'Eri opinion that applicant is not substantially incapacitated from the performance of her duties as a CSW at CDCR was well-founded, well supported, and fully and persuasively explained. Dr. Ha'Eri's opinions were founded upon his deep wealth of orthopedic specialty education, training and experience in the focal point of the examination; applicant's claims of orthopedic disability. Dr. Garcia's opinions, by contrast, were well outside his area of expertise, were not supported in either the diagnostic evidence he described, or in any supporting clinical, treatment or medical records of his own care of her introduced in support (there were none). Dr. Garcia's opinions were therefore unpersuasive and lacking in credibility. Particularly harmful to the credibility and persuasiveness of Dr. Garcia's opinions was his reliance upon what Dr. Ha'Eri pointed out was a single and rather subjective piece of diagnostic evidence, Dr. Do's EMG, that made conclusions that appear to be inaccurate in comparison with the recitation of its own protocol, and at odds with the clinical findings of Dr. Torres, Dr. Maclean and Dr. Ha'Eri on physical examination. Dr.

Garcia's rather hyperbolic opinion in his letters that applicant suffers from "severe chronic osteoarthritis" in her low back and her knees, despite the fact that there exist two MRIs in the record that are entirely normal and refute such a diagnosis, did great harm to his credibility about applicant's orthopedic conditions in his medical opinions.

96. The evidentiary record here does not contain medical evidence supportive of a conclusion that applicant is substantially incapacitated from the performance of her duties as a CSW as a result of the orthopedic condition of her wrists, low back, knees, ankles, or feet, or any combination thereof. Applicant failed to prove by a preponderance of the medical evidence that any or all of her claimed disabling orthopedic conditions render her permanently disabled; i.e., substantially unable to perform her usual and customary duties as a CSW for CDCR.

LEGAL CONCLUSIONS

1. "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."²⁰

2. "If the medical examination and other available information show to the satisfaction of the board ... that the member is incapacitated physically or mentally for the performance of his or her duties in the state service and is eligible to retire for disability, the board shall immediately retire him or her for disability...."²¹

3. "We hold that to be 'incapacitated for the performance of duty' within section 21022 means the substantial inability of the applicant to perform his usual duties."²² *Mansperger* continues to be the definitive statement of California courts to date regarding the meaning of the language of section 21156, "incapacitated for the performance of duty," in the context of an application for a disability retirement.

4. In applying the *Mansperger* standard, it has been held that the fact that a person has a limiting and painful physical condition, or an emotionally troubling psychological condition that limits, but does not preclude, the person's ability to perform his or her usual duties; or makes performing the usual and customary duties of one's occupation more difficult or unpleasant physically or mentally does not necessarily constitute a

²⁰ Government Code section 20026, in pertinent part.

²¹ Government Code section 21156, in pertinent part.

²² *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App. 3d 873, 876.

substantial incapacity for the purposes of a disability retirement.²³ The fact that the physical or psychological condition may preclude the applicant from performing some but not all usual and customary job duties does not necessarily mean the applicant is substantially incapacitated within the meaning of *Mansperger* and section 21156.²⁴

5. Applicant failed to meet her burden of proof to present credible and persuasive medical evidence that she is substantially incapacitated from the performance of her duties as a CSW for CDCR, as set forth in the factual findings. Applicant did prove a period of temporary disability immediately following her fall down the stairs on November 20, 2012. Applicant was found fit and able to return to work in late February, 2013. But as Dr. Ha'Eri persuasively pointed out, the sprain/strain injuries she suffered, confirmed by x-rays and MRI to have caused no permanent harm, should have fully healed with conservative treatment during the following year, and if not, the problem is elsewhere besides a work-related incapacity. Applicant's claims of cumulative disabilities, none of which are individually significant enough to constitute substantial incapacity, but combined allegedly substantially incapacitate her, lack merit. Applicant's claims of pain, disability and incapacity fit squarely into the authority of *Hosford*, above, where it is evident that applicant is orthopedically capable of returning to work, but some of her work activities and obligations will be more difficult and more uncomfortable than before her fall down the stairs.

6. Most of applicant's claims of pain, disability and incapacity, as pointed out quite credibly and persuasively by Dr. Ha'Eri, and confirmed in part by Dr. Maclean's AME and Dr. Mangat's assessment, are the product of nonindustrial causes that would exist even if applicant had never worked for CDCR, such as an automobile accident in which applicant injured her back, knees and feet, and evidently set off her plantar fasciitis problem, as well as the consequence of years of morbid obesity. None of these causes are assignable to a work-related or work-caused disability. The fact that *Hosford's* and applicant's work duties may become more difficult and uncomfortable to perform as the consequences of a work injury does not necessarily constitute industrially caused substantial incapacity within the definitions set forth above in the Government Code provisions, *Mansperger* and *Hosford*. The well-settled rule that pension provisions should be liberally construed does not apply to provide a benefit where the applicant for the benefit does not meet the threshold requirements to receive it.

The Effect of Workers Compensation Imposed Work Limitations/Restrictions

7. Applicant contended that some of the medical determinations of her Workers Compensation doctors finding disability should also result in a similar conclusion here. Applicant's Worker's Compensation cases are contested, and there is no evidence that she has received an award finding her temporarily or permanently disabled. Even had she

²³ *Hosford v. Board of Administration* (1978) 77 Cal.App. 3d 854, 861-863.

²⁴ *Id.*

received such an award and/or determination from the Worker's Compensation system, the existence of a Workers Compensation finding or award of disability compensation is not determinative, does not constitute collateral estoppel on any disputed factual or legal issue in these proceedings, nor does it even constitute persuasive evidence of substantial incapacity, as that term is defined in *Mansperger* and the many cases that follow its authority. The standards of proof required to demonstrate a compensable injury in the no-fault Workers Compensation system are significantly different than those required to meet the proof threshold for substantial incapacity, and thus eligibility for a disability retirement. The Workers Compensation and disability systems have different objectives and different mechanisms to evaluate what constitutes compensable injuries or conditions. Even a finding of permanent total disability under the Worker's Compensation standards does not necessarily equate to and require a finding of substantial incapacity in the disability retirement system. The nomenclature and the rating system of the Workers Compensation system for disability finds no parallel, and has no correlate, in evaluating whether a person is substantially incapacitated from the ability to perform their usual and customary job duties.

8. The quantum of credible medical evidence required to prove a compensable injury in the Workers Compensation system is considerably less than that required to meet the substantial incapacity threshold for a disability retirement. Applicant's receipt of an award in a Workers Compensation case has no material impact on the determination that must be made here, and is not material to the determination of whether her claims of substantial incapacity have credible and persuasive medical evidentiary support. Even a finding of permanent total disability under the Worker's Compensation standards does not equate to and require a finding of substantial incapacity in the disability retirement system. The nomenclature and the rating system of the Workers Compensation system for disability finds no parallel and has no meaning in evaluating whether that same applicant is substantially incapacitated from the ability to perform their usual and customary job duties.

9. The existence of physician-imposed workplace limitations and restrictions do not equate to substantial incapacity to perform the ordinary and customary requirements of one's employment. Workplace restrictions and limitations imposed through a physician or other healthcare provider through Workers Compensation can address a potentially wide variety of situations, and may relate to either temporary, partial or total incapacity, or longer lasting conditions, up to and including permanent disability. Workers Compensation work restrictions can reflect conditions or pathology that may or may not be substantially incapacitating. Worker's Compensation remedies and the system that provides them focus on and address an entirely different set of concerns than does disability retirement, and applies different standards and a different analytical evaluative process in determining what constitutes compensable conditions.

Conclusion

10. The medical evidence does not support a claim of substantial incapacity on the basis of orthopedic conditions in applicant's wrists, low back, legs, knees, or feet, or all of them in combination. The medical evidence upon which applicant relied in support of her

application was credibly and persuasively discredited by Dr. Ha'Eri, also corroborated by the hearsay reports of Dr. Torres, Dr. Mangat and portions of Dr. Maclean's AME. The legal standards for proof of substantial incapacity require more than what applicant presented. The medical evidence upon which this Decision may rely to make Factual Findings and Legal Conclusions do not support applicant's claim of substantial incapacity, or that her continuing claims of pain, disability and incapacity are industrial, as her claims were not proved to have been the product of her work injury or work activity.

11. Since applicant failed to meet her burden to prove by competent medical opinion that she is substantially incapacitated within the *Mansperger* standard, her appeal of the CalPERS BSD's denial of her application must be dismissed, and the denial upheld.

ORDER

The appeal of Armedia Hernandez of the CalPERS BSD's denial of her application for an industrial disability retirement is **DISMISSED**. The determination of CalPERS's Benefits Services Division that applicant is not substantially incapacitated from performing her duties as a Clinical Social Worker for the CDCR, and that her application for industrial disability retirement should be denied, is **AFFIRMED**. Applicant's service retirement benefit continues without change.

DATED: March 30, 2016

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STEPHEN J. SMITH
Administrative Law Judge
Office of Administrative Hearings