

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:

CANDICE R. BAILEY,

Respondent,

and

TUOLUMNE COUNTY SCHOOLS.

Respondent.

Case No. 2015-0022

OAH No. 2015050677

PROPOSED DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings, on March 1, 2016, in Sacramento, California.

The California Public Employees' Retirement System (CalPERS) was represented by Ashante L. Norton, Deputy Attorney General.

Candice R. Bailey appeared on her own behalf.

There was no appearance by, or on behalf of, the Tuolumne County Schools.¹

Evidence was received in the form of documents and testimony, the record was closed and the case was submitted for decision on March 1, 2016.

FACTUAL FINDINGS

1. Candice R. Bailey (respondent) was employed as a Human Resources Technician by the Tuolumne County Schools. By virtue of her employment, respondent is a

¹ Compliance with service requirements under Government Code sections 11504 and 11509 was established. With respect to the Tuolumne County Schools, this matter proceeded by way of default under Government Code section 11520.

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local miscellaneous member of CalPERS subject to Government Code section 21150.² She has the minimum service credit necessary to qualify for retirement. On April 16, 2013, respondent filed an application for service pending disability retirement with the Benefits Services Division of CalPERS. In filing the application, respondent claimed disability on the basis of an internal (Crohn's disease) condition.

2. CalPERS obtained and received medical reports concerning respondent's internal condition from competent medical professionals. After reviewing the reports, CalPERS determined that respondent was not permanently disabled or incapacitated from performance of her duties as a Human Resources Technician at the time her application for disability retirement was filed.

By letter dated August 22, 2014, CalPERS notified respondent of its determination and advised her of her appeal rights. On September 12, 2014, respondent filed an appeal and request for hearing. CalPERS filed a Statement of Issues on March 3, 2015. Per the Statement of Issues, respondent's appeal is limited to the issue of whether, on the basis of an internal (Crohn's disease) condition, she is permanently disabled or incapacitated from performance of her duties as a Human Resources Technician for the Tuolumne County Schools.

Job Duties

3. Respondent worked as a Human Resources Technician for the Superintendent of Schools, Tuolumne County. The Duty Statement for respondent's position provides as follows:

Under the direction of the Director of Human Resources, perform a variety of human resources activities involved in the recruitment, screening, credentialing and processing of County Office personnel, establish and maintain personnel records and files, provide a variety of clerical and administrative support services for the Department.

4. Human Resources Technician work is comprised largely of clerical functions. Representative duties included serving as an informational resource for employees, schools, applicants and the public regarding personnel functions, and also responding to inquiries and "provide information concerning related standards, time lines, position vacancies, requirements, laws, regulations, practices, policies and procedures." Physical requirements of the position required frequent (3 – 6 hours) sitting, standing, walking and lifting.

² 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."

Respondent's Medical and Work History

5. Respondent described her disability as Crohn's disease dating back to March 25, 1985, when she underwent surgery for bowel resection. After surgical resection her condition improved and she was in remission for approximately 10 years. In 1995, she experienced symptoms including pain in her right side, nausea and diarrhea. She was followed at that time by William Griffiths, M.D. In 1998 she was admitted to the hospital with obstructive symptoms. As her condition progressed, she underwent a second surgical bowel resection in 2010. Her condition worsened following this surgery. She experienced localized right-sided pain, more so in the right upper than the right lower quadrant, and associated diarrhea of loose or watery bowel movements. She also experienced fatigue. Her symptoms continued, but leveled off over time. However, the diarrhea never ended despite different medications.

Dr. Griffiths retired in 2014, and gastroenterologist Waleed Ibrahim, M.D., took over her care. He confirmed her diagnosis of Crohn's disease, and prescribed medications for this condition including Cimzia, a medication approved for adults with moderate to severe active Crohn's disease.

6. Respondent's last day at work was April 30, 2013. Over the period up until then she continued to experience diarrhea and fatigue. She had up to 20 loose bowel movements per day, and often did not make it to the restroom without having an accident. Some days she could not make it to work without having diarrhea. At work, her employer was very supportive of her, and accommodated her by changing her position so she could be nearer to the restroom. Respondent limited her food and fluid intake in the morning to avoid having bowel movements. She did not go anywhere without having an extra change of clothes. She took a bucket with her when she traveled in her car. For three years she attempted to manage her condition so that she could continue working. She stayed on the job "through the embarrassment of having accidents at work." She did not want to retire. At hearing, her husband confirmed that her condition has made everything a struggle for her.

7. In her application for disability retirement respondent indicated her work limitations/preclusions due to her illness as being "difficult getting to the restroom without accident." She also noted on her application that her illness caused her "fatigue, away from my desk often to use the restroom."

Respondent did not return to work. She has not been employed in any other position since that time. She retired from service effective May 1, 2013.

Medical Reports/Evaluations

8. David Allen, M.D. Dr. Allen prepared a CalPERS form Physician's Report on Disability on August 20, 2015. He described respondent's condition as a chronic illness of Crohn's disease that had progressed over the last three to four years "until unable to work." He noted objective examination findings in support of Crohn's disease that included

“stricture on colonoscopy” and Crohn’s disease on colon biopsy. He noted that respondent was unable to work during the active flare of disease, and that her condition was associated with fatigue, lethargy and a decrease in general strength. He further commented that respondent “has chronic fatigue relative to active bowel inflammation” leading to periodic nausea and abdominal pain.

9. Eric Freedman, M.D. Dr. Freedman is a urologist. In a separate CalPERS form Physician’s Report on Disability dated August 19, 2015, Dr. Freedman diagnosed respondent as having Crohn’s disease, with a secondary diagnosis of Ureteral stones. Dr. Freedman attached his Preoperative History and Physical dated November 19, 2014. She underwent surgery for removal of stones. He indicated that “because of her Crohn’s, she would be prone to stone formation on the basis of diarrhea, dehydration, metabolic acidosis, and malabsorption from previous small bowel inflammation and surgery.”

10. William J. Griffiths, M.D. Dr. Griffiths prepared reports following his examinations of respondent between September 2012 and May 2014. In a report dated September 20, 2012, he described respondent’s active problems as Crohn’s disease and hypertension. She complained of intermittent episodes of abdominal pain, cramping and loose stools. She had been referred to Dr. Griffiths by Dr. Allen. Dr. Griffiths noted that if her symptoms worsened, he would consider prescribing Cimzia “since it does not contain a Murine component, but nevertheless would be somewhat risky.”

Dr. Griffiths prepared a report after his April 8, 2013 examination of respondent. She was “still having problems with loose stools [and] the feeling of constant discomfort.” He described her condition as Crohn’s disease post resection and continued her on her current medications. Dr. Griffiths saw her again on July 22, 2013. She complained of having “intermittent episodes of nausea diarrhea and abdominal discomfort.” Dr. Griffiths saw her again on September 9, 2013. She complained of still having problems with discomfort in the right lower quadrant.

Dr. Griffiths saw respondent on May 6 and 20, 2014. She reported “still having a lot of problems with intermittent loose stools [and] abdominal cramping.” Dr. Griffiths added additional medications which did not result in improvement.

11. Waleed Ibrahim, M.D. Dr. Ibrahim prepared reports following his examinations of respondent in 2015. Dr. Ibrahim saw her on January 7, 2015. He noted that she has a history of Crohn’s disease, as well “inflammatory bowel disease complicated by bowel obstructions in the past and multiple surgeries with the partial bowel resections involving the terminal ileum in 1985 and 2010.” She was started on Cimzia in August 2014.

Dr. Ibrahim saw her more recently on August 11, 2015. He provided the following summary of her condition at that time:

The patient underwent a colonoscopy on July 20, 2015 revealing large external and internal hemorrhoids. There was evidence of

previous surgery with ileocolonic anastomosis. There was a stricture at the anastomotic site which did not allow passage of the colonoscope into the terminal ileum. The remainder of the colon otherwise was normal. Biopsies from all these sites were unremarkable. Biopsies from the anastomotic site showed reactive changes, edema and hemorrhage. There were no granulomatous changes or any findings to suggest inflammatory bowel disease.

Currently, the patient has diarrhea with 8-10 BM/day which is unchanged since the last visit. She has multiple symptoms with diarrhea and abdominal pain prior to Cimzia.

Dr. Ibrhahim's August 11, 2015 report was missing the second page.

12. Michael M. Bronshvag, M.D. On July 9, 2014, respondent was evaluated by Michael M. Bronshvag, M.D. pursuant to a referral by CalPERS for an independent medical examination. Dr. Bronshvag is Board Certified in Internal Medicine and Neurology. He does not specialize in gastroenterology. He prepared an evaluation report dated July 9, 2014, and supplemental reports dated October 8, 2014, and February 18, 2016. He also testified at hearing. He was provided with respondent's medical records, including the medical reports summarized above.

13. Dr. Bronshvag acknowledged that respondent has been diagnosed with Crohn's disease since 1985 by her treating physicians, but is not persuaded that she has active Crohn's disease at this time. He does not rule this diagnosis out, but he also does not believe the medical evidence and data clearly support this diagnosis. His diagnostic impression includes: "Ongoing abdominal and intestinal difficulties with further bowel resection in 2010." He understood that she was being treated for Crohn's disease with a "number of agents" and that the most prominent of her symptoms was "inability to control her bowels and the need to be very close to a bathroom." Dr. Bronshvag explained why he does not believe her symptoms are due to Crohn's disease:

It is, thus, not entirely clear to what extent the claimant's difficulty is better described as inflammatory bowel disease as opposed to irritable bowel syndrome. There is a history of gallbladder disease and her areas of symptomatology/pain is in the right abdomen (currently right upper quadrant and previously right lower quadrant). The medical records as provided do not document striking current radiologic or endoscopic abnormalities, and the claimant has indeed had a weight gain. It is not entirely clear therefore – to what extent this claimant's difficulties represent inflammatory bowel disease of the small and large bowel (Crohn's disease, and Crohn's colitis), as opposed to other factors. It is not clear whether

obtaining the 1985 appendectomy records might provide useful information. It is possible that there are other records out there demonstrating imaging and endoscopic abnormalities in the abdomen, which would clarify her situation.

Given the absence of this information, Dr. Bronshvag indicated that it was not possible at that time to confirm an opinion of permanent disability. He noted that the medical records he had been provided and the physical findings at that time did not “sufficiently correlate with the description by the claimant of her difficulties to preclude any of her usual job duties.” He believed further appropriate studies would include an abdominal intestinal MRI without and with contrast, and contemplation of an upper GI series with small bowel follow through, and alternatively an endoscopic study of the colon.

14. Dr. Bronshvag was provided Dr. Griffiths’ July 2013 Physician’s Report on Disability. He prepared a supplemental report dated October 8, 2014, indicating that his opinion had not changed. Dr. Bronshvag noted that Dr. Griffiths had not completed most of the required form and that he had made no mention of respondent’s “member history, examination findings, diagnosis, and there is no description of current radiologic and other studies which would confirm the diagnosis of currently active Crohn’s disease.” Dr. Bronshvag reiterated his expectation that patients with active Crohn’s disease would have abnormal physical findings and abnormal radiologic findings. And that “if gastroenterology specialist Dr. Griffiths or other similar specialist can present evidence (as opposed to opinion) relevant to the presence of active Crohn’s disease I would of course weigh such data heavily.”

15. Dr. Bronshvag was provided with further data, including Dr. Ibrahim’s July 20, 2015 medical record, and Dr. Allen’s August 20, 2015 report. He was also provided with the 2010 operative report. Dr. Bronshvag did not change his opinion regarding the presence of active Crohn’s disease based upon this new information. He explained:

At the present time I am provided with potentially crucial documentation from July 2015 (a 2-page colonoscopy report and mention of biopsies); however, I am not provided with page two of the report, which contained the doctor’s conclusions, and the results of the biopsies.

If the colonoscopy and biopsies were to be read as normal, as was suggested by the August 2015 note of Dr. Ibrahim, as was the 2009 colonoscopy, those would be pertinent data in favor of the conclusions I had reached in 2014.

On the other hand, if the 2015 colonoscopy demonstrated small bowel obstruction, and the biopsies demonstrated active colitis or Crohn’s, which they did not, that would be equally important.

...

The full report of the July 2015 colonoscopy and biopsies will be useful to sort out between subjective issues and objective issues. The impact of the medicines she is receiving needs to be reviewed. A repeat evaluation in 2016 of the patient by myself or another IME consultant seems indicated relevant to newer and important but somewhat contradictory data just received.

16. At hearing, Dr. Bronshvag testified in a manner consistent with his above described IME report and supplemental reports. He recognized that respondent had the symptoms and difficulties she described. He does not dispute that she was correctly diagnosed with Crohn's disease in 1985. He acknowledged that her treating gastroenterologists both diagnosed her with Crohn's disease, and that she is receiving a medication (Cinzia) that is prescribed for this specific condition. Cinzia is prescribed for both active Crohn's disease, and also prophylactically.

17. Dr. Bronshvag cannot confirm an opinion of permanent disability until it becomes clearer to him what is causing her difficulties. However, he does agree that with the passage of time in this case, it is not unreasonable to conclude that she has a permanent condition.

Discussion

18. Respondent has the burden of demonstrating through competent medical evidence that she is permanently disabled or incapacitated from performance of her duties as a Human Resources Technician with the Tuolumne County Schools. She has done so.

Her symptoms prevent her from performing her regular duties. Her condition is associated with fatigue, lethargy and a decrease in general strength. Her diarrhea symptoms are not well controlled, requiring her to use a bathroom up to 20 times per day.

19. Dr. Bronshvag has pointed to the lack of medical evidence and data in the records he reviewed to support a diagnosis of Crohn's disease. He acknowledged that two gastroenterologists have diagnosed respondent with Crohn's disease, but he would also like to review the supporting data and medical evidence to confirm their diagnosis. He concedes that he did not read Dr. Ibrahim's conclusions set forth in the July 20, 2015 records. They were contained on a missing page of this endoscopy report. Dr. Bronshvag was not provided with an opportunity to read the biopsy results, which was presumably reviewed by respondent's gastroenterologists. Dr. Bronshvag does not rule out Crohn's disease as a possible diagnosis and reason for respondent's difficulties. He agrees that she is being treated for Crohn's disease. And that at least one of her medications is specifically prescribed for this condition. He also acknowledged that with the passage of time, her condition has likely become permanent.

20. Dr. Bronshvag was provided with the June 28, 2010 operative report. He indicated that this report described "two small patches of colitis at this time, which were

resected.” The report stated more than that. This report was prepared by the surgeon, Niamh M. Seavy, M.D. The preoperative and postoperative diagnosis was listed as “Partial bowel obstruction and Crohn’s disease.” The operative findings described: “Two areas of Crohn disease proximal to the old anastomosis causing partial obstruction.” The operative procedure notes contained the following observation:

Small bowel was inspected. Apart from what appeared to be a color change between the jejunum and the ileum where the ileum appeared much redder than the jejunum, there was no other obvious evidence of residual Crohn’s disease.

There was a separate Discharge Summary that indicated respondent’s discharge diagnosis as: “Crohn disease with partial bowel obstruction.” The exploratory laparotomy that was performed “showed 2 areas of what appeared to be recurrent Crohn’s disease just proximal to her anastomosis.”

21. At least two specialists in gastroenterology have diagnosed respondent with Crohn’s disease. Her primary care physician diagnosed her with this condition and referred her to specialists for treatment of this condition. Her surgeon described two areas described as “recurrent Crohn’s disease” that Dr. Bronshvag chose instead to more generally describe as “colitis.” Respondent is being provided treatment very specific to Crohn’s disease. Her symptoms are consistent with this diagnosis. And Dr. Bronshvag has not ruled Crohn’s disease out as a possible diagnosis. He also agrees that it is not unreasonable to characterize her present condition as permanent.

22. For all the above reasons, respondent has demonstrated through competent medical evidence that she is permanently disabled or incapacitated from performance of her duties as a Human Resources Technician with the Tuolumne County Schools. Accordingly, her application for disability retirement should be granted.

LEGAL CONCLUSIONS

1. Under Government Code section 21150, members incapacitated for the performance of duty shall be retired for disability. Government Code section 20026 provides that “‘Disability’ and ‘incapacity for performance of duty’ as a basis of retirement, means disability of permanent or extended and uncertain duration, as determined by the board... on the basis of competent medical opinion.” In *Mansperger v. Public Employees Retirement System* (1970) 6 Cal.App.3d 873, the court construed the term “incapacitated for the performance of duties” to mean a substantial inability to perform the employee’s usual duties. (*Id.* at p. 876.) The applicant in *Mansperger* was a warden with the Department of Fish and Game whose physician opined that he could no longer perform heavy lifting and carrying. The evidence established that such tasks were an infrequent occurrence, and the applicant’s customary activities were the supervision of hunting and fishing. The *Mansperger* court found

that the applicant was not entitled to disability retirement because, although he suffered some physical impairment, he could perform most of his usual job duties.

2. Subsequently, in *Hosford v. Board of Administration of the Public Employees' Retirement System* (1978) 77 Cal.App.3d 854, the Court of Appeal applied the *Mansperger* test to the disability retirement claim of a California Highway Patrol Sergeant who sustained injuries to his back and leg, which restricted his ability to carry out some of the functions of a patrol officer, including driving a patrol car for lengthy periods. Regarding whether there must be actual present disability, or whether fear or possibility of future injury is sufficient to find disability, the court noted that "Hosford relied and relies heavily on the fact that his condition increases his chances for further injury . . . this assertion does little more than demonstrate that his claimed disability is only prospective (and speculative), not presently in existence." The *Hosford* court held that the disability or incapacity must presently exist and that a mere fear of possible future injury which might then cause disability or incapacity was insufficient. (*Id.* at p. 862.)

3. Respondent has the burden of proving entitlement to disability retirement. (*Harmon v. Board of Retirement of San Mateo County* (1976) 62 Cal.App.3d 689, 691; *Rau v. Sacramento County Retirement Board* (1966) 247 Cal.App.3d 234, 238.) It is well accepted that CalPERS may rely on decisions affecting other pension plans when the laws are similar, and since Government Code section 31724 (County Employees' Retirement Law) is similar to Government Code section 21151 (California Public Employees' Retirement Law), the rule concerning burden of proof shall be applied to cases under CalPERS law. (*Bowman v. Board of Pension Commissioners for the City of Los Angeles* (1984) 155 Cal.App.3d 937, 947.)

4. The matters set forth in Findings 5 through 22 have been considered. It was established through competent medical evidence that respondent has an internal condition (Crohn's disease) that substantially disables her from the performance of her usual and regular duties as a Human Resources Technician with the Tuolumne County Schools.

ORDER

The application of Candice R. Bailey for disability retirement is granted.

DATED: March 4, 2016

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JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings