

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:

KAREN K. PARKER,

Respondent,

and

DEPARTMENT OF MENTAL HEALTH,
NAPA STATE HOSPITAL,

Respondent.

Case No. 8937

OAH No. 2014050179

PROPOSED DECISION

This matter was heard before Administrative Law Judge Marcie Larson, State of California, Office of Administrative Hearings, on March 28, 2016, in Sacramento, California.

The California Public Employees' Retirement System (CalPERS) was represented by John Mikita, Senior Staff Attorney.

Adam Blair Corren, Attorney at Law, represented Karen Parker (respondent) who was present at the hearing.

There was no appearance by or on behalf of the Department of Mental Health (Department), Napa State Hospital. The Department was duly served with Notices of Hearing. The matter proceeded as a default against the Department, pursuant to California Government Code section 11520, subdivision (a).

Evidence was received, the record was closed, and the matter was submitted for decision on March 28, 2016.

PUBLIC EMPLOYEES RETIREMENT SYSTEM

FILED *April 19, 2016*
Rachelle E. Sekretz

ISSUE

The issue on appeal is whether, on the basis of the condition of respondent's left shoulder (orthopedic condition), respondent is permanently disabled or incapacitated from performance of her duties as a Rehabilitation Therapist (RT) for the Department?

PROCEDURAL FINDINGS

1. On May 21, 2007, respondent signed and thereafter filed an application for industrial disability retirement (application) with CalPERS. The last date respondent worked as a RT for the Department was June 16, 2006. By virtue of her employment respondent is a state safety member of CalPERS subject to Government Code section 21151.

2. In filing the application, respondent claimed disability on the basis of an injury to her left shoulder (orthopedic condition), that she alleged occurred at work on July 19, 2003.

3. CalPERS obtained medical records and reports, including reports prepared by Noah Weiss, M.D., and Joseph Serra, M.D., who conducted an Independent Medical Evaluation of respondent concerning respondent's orthopedic condition. After reviewing the reports, CalPERS determined that respondent was not permanently disabled or incapacitated from performance of her duties as an RT for the Department.

4. On June 18, 2008, CalPERS notified respondent that her application for industrial disability retirement was denied. Respondent was advised of her appeal rights. Respondent filed an appeal and request for hearing by letter dated July 8, 2008.

5. On May 2, 2014, Anthony Suine, in his official capacity as Chief, Benefit Services Division, Board of Administration, CalPERS, made and thereafter filed the Statement of Issues.

FACTUAL FINDINGS

Respondent's Employment History and Work Injury

1. In June 2003, respondent was hired to work as an RT at the Department's Sonoma Developmental Center (Sonoma). Many of the Sonoma patients used wheelchairs. On July 19, 2003, respondent injured her left shoulder at work. Respondent was bent over, belting a client into a wheelchair inside a van. Respondent rose up and struck her left shoulder on an overhang on the wheelchair. She experienced pain in her left shoulder. Respondent did not seek medical treatment until February 2004, when she saw Trish Stagg, M.D.

2. In March 2004, respondent transferred to Napa State Hospital (Napa) to work as an RT. Respondent selected Napa because the RT position did not require that she push or pull wheelchairs, which she found difficult to do because of her left shoulder pain. When respondent transferred to Napa, she had no work restrictions. Respondent worked at Napa until June 16, 2006. She was 60 years old. Respondent contended that she stopped working for Napa because she was unable to perform management of assaultive behavior (MAB).

Duties of a Rehabilitation Therapist

3. Napa is mental health facility that serves the mental health care needs of adult clients who committed crimes, but were unable to stand trial or be incarcerated at a prison, due to mental health issues.

4. As set forth in the duty statement signed by respondent on August 8, 2005, as a RT at Napa, respondent was required:

To provide rehabilitative programs and services through appropriate client/patient assessment, treatment, service planning, therapeutic activities, discharge planning and community reintegration by using the principles and practices of these disciplines to develop, maintain, or restore physical, emotional, and social competencies.

Respondent was also required to apply and demonstrate “knowledge of correct methods in the management of assaultive behavior (MAB).”

5. At hearing, respondent submitted a “Job Analysis” for a “Generic” RT position at Napa, date July 21, 1999. The following information was provided regarding MAB under the heading “OVERVIEW OF ONGOING REQUIREMENTS:”

For the protection of the therapist, treatment staff and clients themselves, Management of Assaultive Behavior (MAB) is required of all direct support staff. It was noted that depending on the unit the rehabilitation therapist is working on, there could be up to four incidents of MAB per day. MAB may be verbal intervention or physical intervention.

A Special Order dated February 27, 1991, mandates that all treatment staff complete the following:

- A. New hire shall take a modified basic MAB course consisting of all sections of the MAB staff work book (approximately 16 hours).

- B. All treatment staff team shall take 6 to 8 hours of MAB review annually, and shall take the review MAB together as a unit team whenever possible.
- C. The review MAB will include walk-through performance of self-protection and physical interventions, and will also be tailored to the express needs of the unit.

6. Respondent was aware when she transferred to Napa in March 2004, that she was required to perform MAB. She completed the required MAB team training on January 18, 2005.

7. On March 15, 2007, respondent signed a "Physical Requirements of Position/Occupational Title" form (Physical Requirements form). The Physical Requirements form was submitted to CalPERS. According to the Physical Requirements, when working as a RT, respondent: (1) frequently (three to six hours a day) engaged in fine manipulation; (2) occasionally (up to three hours) sat, stood, walked, crawled, kneeled, climbed, squatted, bent and twisted at her neck and waist, reached above and below the shoulders, pushed and pulled, power and simple grasped, repetitively used her hands, used a keyboard and mouse, lifted from 0 to 50 pounds, walked on uneven ground, drove, was exposed to excessive noise; and (4) never lifted over 50 pounds, worked with heavy equipment, worked at heights, operated foot controls or repetitive movement, or used special visual or auditory protective equipment, or worked with bio-hazards. Under the "comments or additional requirements" it was noted that driving was required occasionally and recycling was also a requirement of a RT.

Medical Records, Reports and History of Treatment

8. At hearing, respondent submitted numerous medical records and reports, including records and reports from Trish Stagg, M.D., Roger Dainer, D.O., Ibrahim Yashruti, M.D., Stephen John Franzion, M.D., Noah Weiss, M.D., and Robert McIvor, M.D., who testified at hearing. Many of the reports are addressed to the State Compensation Insurance Fund (SCIF) and relate to respondent's workers compensation claim. Other than the reports from Dr. McIvor, the remaining records and reports were admitted as administrative hearsay, and have been considered to the extent permitted under Government Code section 11513, subdivision (d).

RECORDS OF TRISH STAGG, M.D.

9. The first document related to respondent's left shoulder injury was an "Employee Work Status Sheet," dated February 18, 2004, signed by Trish Stagg, M.D. Respondent was employed at Sonoma at the time. Dr. Stagg diagnosed respondent with left shoulder strain. Dr. Stagg instructed respondent to "continue full duty." Respondent had no work or activity restrictions. Respondent was advised to participate in occupational therapy for two sessions.

10. A Work Status Report dated March 11, 2004, signed by Dr. Stagg, indicated that respondent "had a recent job change which will involve less pushing of wheelchairs." The job change referred to respondent's transfer to Napa. Dr. Stagg instructed respondent to continue her "full duty." Respondent was ordered to do home exercises and continue occupational therapy.

11. Dr. Staggs also completed a "Doctor's First Report of Occupational Injury or Illness" form that was received by the Department on March 15, 2004. Dr. Stagg wrote that she first examined Respondent on February 11, 2004, related to respondent's shoulder injury. Dr. Stagg indicated that respondent was diagnosed with left trapezius strain. Dr. Stagg also wrote that respondent was able to perform her full duties.

RECORDS OF C. LEE NEWMAN, M.D.

12. On May 4, 2005, C. Lee Newman, M.D., with Job Care, an occupational health clinic, completed an "Injury Status Report." For the first time since respondent was injured on July 19, 2003, she was given work restrictions. Dr. Newman wrote that respondent was restricted to no overhead lifting with her left side, no "firm grasping, pushing or pulling" on her left side and "no MAB." These restrictions remained in place until at least June 21, 2005.

RECORDS OF STEPHEN JOHN FRANZINO, M.D.

13. Dr. Newman referred respondent to Dr. Franzino, M.D., with St. Helena Sports Medicine & Orthopaedics. Dr. Franzino evaluated respondent on August 24, 2005. Dr. Franzino obtained a history of respondent's injury. Respondent informed Dr. Franzino that she had "moderate to severe" left shoulder pain. She had "no feeling of catching or instability" in her shoulder. She felt "weakness with any overhead activities and abduction."

Dr. Franzino reviewed available medical records and a magnetic resonance imaging (MRI) taken of respondent's left shoulder on August 1, 2005, which indicated "Type II acromion, chronic anterior labral tear." He also conducted a physical evaluation. Dr. Franzino diagnosed respondent with "shoulder impingement." He opined that the MRI findings were "consistent with impingement syndrome and bursitis." He further stated that the "mechanism of injury does not support the MRI concerning an anterior labral lesion." Dr. Franzino treated respondent with a "corticosteroid injection into the subacromial space." He noted that respondent had "immediate pain relief as well as increased range of motion." Dr. Franzino recommended that respondent "continue with her rotator cuff exercises." He also prescribed her Vicodin for pain. Dr. Franzino wrote that he was "happy to take over her care concerning her left shoulder." He also recommended that she continue modified duty and limit her overhead repetitive activities.

14. At hearing, respondent testified that Dr. Franzino recommended surgery for her left shoulder. She did not want to have surgery, so she sought a second opinion with Dr. Weiss, who ultimately performed three surgeries on respondent's left shoulder. There is no

indication in the report prepared by Dr. Franzino that he recommended respondent undergo surgery.

RECORDS OF NOAH WEISS, M.D.

15. On December 8, 2005, Dr. Weiss examined respondent and prepared a report addressed to SCIF. Dr. Weiss wrote that respondent was referred to him by Dr. Newman for an "orthopedic surgery consultation." Dr. Weiss noted that respondent's left shoulder was treated with a "corticosteroid injection with no relief in August 2005."

16. Dr. Weiss obtained a history of respondent's injury and work status. Dr. Weiss noted that respondent had "no periods of disability or modified duty." Dr. Weiss also conducted a physical examination of respondent. He reviewed MRIs taken on August 1, 2005, and December 2, 2005, and a "fluoroscan impingement series" of respondent's left shoulder taken on the day of the examination. He noted a "rather remarkably hooked or type III acromion." Dr. Weiss diagnosed respondent with:

1. Anterior labral tear, left shoulder.
2. Left shoulder subacromial impingement/bursitis.
3. Secondary adhesive capsulitis, left shoulder.

17. Dr. Weiss injected respondent's "left shoulder subacromial space" and "left shoulder glenohumeral joint" with Lidocaine. Dr. Weiss noted that a result of the injections, respondent had "excellent pain relief."

18. Dr. Weiss recommended that respondent undergo left shoulder arthroscopy. He opined that she required:

[A]n arthroscopic labral repair or capsulorrhaphy as well as an arthroscopic subacromial decompression and probable distal clavicle resection, and an arthroscopic capsular release to recover range of motion.

19. On January 5, 2006, Dr. Weiss reevaluated respondent and prepared a report addressed to SCIF. Dr. Weiss noted that respondent had "continued to work at her usual and customary duties." Respondent reported that her shoulder was "steadily worse." She indicated that she was "miserable" and wanted to undergo surgery.

20. On January 10, 2006, Dr. Weiss performed left shoulder arthroscopy. Specifically, the procedures performed included:

1. Left shoulder manipulation under general anesthesia.

2. Left shoulder arthroscopy with debridement of labral tear.
3. Arthroscopic synovectomy, left shoulder.
4. Left shoulder subacromial decompression.
5. Left shoulder arthroscopic distal clavicle resection.

21. On January 25, 2006, respondent was examined by Dr. Weiss. Fluoroscanner imaging of respondent's left shoulder was performed at the visit. Dr. Weiss opined that "everything looks great." Respondent complained of stiffness in her left shoulder and arm. To correct the stiffness, Dr. Weiss administered a local anesthesia to respondent's left shoulder and manipulated her shoulder to help respondent recover her range of motion. Respondent was also directed to continue physical therapy and home exercise. At this time, respondent was on leave from work.

22. On February 27, 2006, respondent was again evaluated by Dr. Weiss. Respondent reported "a lot of progress with physical therapy." She reported soreness and difficulty with "many activities of daily living." Respondent was scheduled to be reevaluated in one month. Respondent remained off work.

23. On March 30, 2006, respondent was evaluated by Dr. Weiss and reported that she was "progressing satisfactorily" and was "quite happy with the results thus far." Dr. Weiss noted that respondent could return to work in two weeks, with "restrictions of MAB."

24. On April 20, 2006, Dr. Weiss evaluated respondent's left shoulder. He noted that she had a "marked increased in range of motion, although recently this seems to have plateaued." He opined that her "biggest problem" was "tenderness over the superior shoulder at the level of the acromioclavicular joint." Respondent reported that it was "very uncomfortable for her to wear a bra for any period of time." She also reported "a lot of difficulty at work with fatigue and pain for more than 4 hours." Fluoroscanner imaging of respondent's acromioclavicular joint was obtained and revealed a "prominent bone spur" on the "distal clavicle." Dr. Weiss opined that if within one month, respondent had "not made any gains in range of motion" she may need to undergo "lysis of adhesions or manipulation under anesthesia" to gain motion in her shoulder, and to remove the bone spur on the "tip of her distal clavicle." Dr. Weiss placed respondent on modified duty with "no MAB, 4 hours a day, 4 days per week."

25. On June 15, 2006, respondent returned to Dr. Weiss for a follow-up appointment. Dr. Weiss noted that respondent was "doing well." She reported "residual ongoing stiffness and tenderness over the superior aspect of the shoulder." Dr. Weiss observed that respondent had developed a "bone spur over the distal clavicle following her distal clavicle resection" and that it was "even more prominent than the last visit." Respondent informed Dr. Weiss that she wanted the bone spur removed. Dr. Weiss also recommended an "arthroscopic debridement and lysis of adhesions" to gain more range of

motion in her left shoulder. Dr. Weiss placed respondent on “temporary disability pending surgery.”

26. Respondent underwent a second surgery on June 30, 2006. Dr. Weiss performed an “open excision of left distal clavicle” and “arthroscopic debridement and lysis of adhesions” on her left shoulder.

27. On July 13, 2006, respondent saw Dr. Weiss for her first post-operative visit. She reported a “marked increase in range of motion.” Dr. Weiss instructed respondent to begin physical therapy the following week and he “tentatively” returned her to work on August 1, 2006. Respondent did not return to work as planned.

28. On August 24, 2006, respondent returned to Dr. Weiss for a follow-up examination. He noted that she had “many questions and concerns.” Respondent was concerned that “there is no longer a bump on the left shoulder acromioclavicular joint and she had a bump on the right side.” He explained that the “goal” of the operation was to remove the “bump” that was causing her symptoms. She also complained of increasing pain on the right side. Dr. Weiss noted on palpation “obvious acromioclavicular joint arthritis of the right shoulder.” Dr. Weiss informed respondent that he was returning her to modified duty on September 5, 2006, with “no use of the left arm at or above shoulder level” and no MAB. Respondent did not return to work as planned.

29. On October 5, 2006, respondent saw Dr. Weiss for a follow-up appointment. He noted that she was making “slow progress” and she complained of “sensitivity over the superior aspect of her shoulder and pain.” She also had difficulty using her left arm overhead. Dr. Weiss conducted a physical examination. Respondent’s range of motion on her right and left sides were exactly the same. Dr. Weiss noted that he was “increasingly concerned about her ability to return to management of assaultive behavior.” He did not articulate why he had this concern.

30. On January 11, 2007, respondent saw Dr. Weiss for a follow-up appointment. She reported “increasing pain in the shoulder.” She also reported a “sense of popping or instability in the shoulder that may be coming from the acromioclavicular joint,” which she felt “all along, from her original injury.” Dr. Weiss conducted a physical examination and noted that she had “excellent range of motion” of her left shoulder. He did not detect any “obvious instability.” Dr. Weiss noted some “osteophytes or bone spurs over the end of the acromion and the distal clavicle.” Dr. Weiss recommended that an “MR scan” be conducted of her left shoulder to “evaluate the coracoclavicular ligaments” and to ensure there was no other injury. Dr. Weiss opined that respondent was “not going to return to her usual and customary duties.”

31. On February 5, 2007, respondent saw Dr. Weiss for a follow-up appointment. The “MR scan” had been conducted and reviewed by Dr. Weiss. The “impression” was a “post surgical scar and soft tissue edema at or about the acromioclavicular joint.” There were no other abnormalities noted. Respondent complained of “significant pain” and a

feeling that her “clavicle is dislocating.” Dr. Weiss examined respondent. He did “not detect any excessive distal clavicle mobility.” Dr. Weiss also noted that respondent was “actually able to manipulate her shoulder” and “reproduce her symptoms.” Dr. Weiss opined that “it appears almost that there may be some scar tissue catching in the acromioclavicular joint.” He did not believe that there was any “hypermobility at the acromioclavicular joint.” Dr. Weiss also noted that respondent had full range of motion on her left side that matched the range of motion on her right side. Fluoroscans imaging was taken at the appointment. It revealed a “satisfactory distal clavicle resection.” Dr. Weiss opined that the distal clavicle resection did not appear to be excessive.

Respondent informed Dr. Weiss that she was “miserable with her shoulder and that something had to be done.” Dr. Weiss informed respondent that scar tissue could be “arthroscopically excised” and he also would be able to “assess hypermobility of the clavicle intraoperatively.”

32. On March 16, 2007, respondent underwent a third surgery. Dr. Weiss performed an “excision of bone spur, open, left acromion process” and “arthroscopic lysis of adhesions and debridement.”

33. On March 26, 2007, respondent had her first post-operative visit with Dr. Weiss. Respondent reported that she felt good and “much improved than her first surgery.” Dr. Weiss also noted that she had “recovered excellent range of motion already.” Dr. Weiss noted that respondent was on “disability” and that she would be “permanently precluded from the management of assaultive behavior.”

34. On June 11, 2007, respondent saw Dr. Weiss for a follow-up appointment. She reported “substantial improvement following surgery” with a “fair amount of weakness and a sense of popping in the shoulder, especially with lifting and reaching.” Dr. Weiss conducted a physical examination and noted that respondent had full range of motion on her left side that matched the range of motion on her right side. He noted a “slight weakness of rotator cuff strength in external rotation, internal rotation, and abduction.” Dr. Weiss gave respondent “permanent restrictions of no management of assaultive behavior, restriction of no more than 10 pounds lifting with the left upper extremity, restrictions against forceful pushing and pulling, and no use of the left upper extremity above shoulder level.” He cleared respondent to return to work on June 12, 2007. However, respondent did not return to work.

35. On August 27, 2007, respondent was examined by Dr. Weiss. Respondent complained of “some pain in her neck and shoulder.” He noted some tenderness over the left neck and “fairly good range of motion.” He noted that she was “very interested in a trial of chiropractic care.” Dr. Weiss recommended a “trial of chiropractic care.” He did not recommend any other treatment.

36. There was no reference in any of the records or reports prepared by Dr. Weiss that he reviewed respondent’s written job description or the physical requirements of her

position. Dr. Weiss also did not opine as to whether respondent was permanently disabled or incapacitated from performance of her duties as a RT for the Department.

RECORDS FROM ROGER DAINER, D.O.

37. On August 28, 2008, respondent had orthopedic consultation with Dr. Dainer. He prepared a report concerning the evaluation. Respondent reported to Dr. Dainer that she had “continued pain, clicking and a sense of instability involving her distal clavicle region” of her left shoulder. Dr. Dainer conducted a physical examination of respondent. He noted that the left shoulder “forward flexion and abduction to 170 degrees with internal rotation to the L1 spinous process.” He also noted a “mild positive impingement sign and abduction sign.” He found “good strength in the external rotation and abduction.” Dr. Dainer reviewed x-rays of respondent’s left shoulder. He noted “excellent decompression of the distal clavicle and subacromial space.”

38. Dr. Dainer diagnosed respondent with “impingement syndrome, left shoulder, surgically treated” and “AC arthrosis, left shoulder surgically treated.” Dr. Dainer wrote that he had “nothing additional to offer from an orthopedic surgical standpoint.” He opined that “she will most probably continue to have the present discomfort involving the left shoulder on an indefinite basis.”

39. There was no reference in the report prepared by Dr. Dainer that he reviewed respondent’s written job description or the physical requirements of her position. Dr. Dainer also did not opine as to whether respondent was permanently disabled or incapacitated from performance of her duties as a RT for the Department.

REPORT FROM IBRAHIM YASHIRUTI, M.D.

40. On April 5, 2010, Dr. Yashruti conducted a qualified medical evaluation (QME) of respondent related to her workers compensation claim for the injury she sustained to her left shoulder. Dr. Yashruti prepared a report date April 26, 2010. Dr. Yashruti noted in his report that he reviewed medical records from Dr. Stagg, Dr. Newman, Dr. Franzino, Dr. Weiss and Dr. Dainer. He also reviewed diagnostic studies.

41. Dr. Yashruti interviewed respondent and obtained information about her job duties, a history of her injury and treatment, and her current complaints. Respondent told Dr. Yashruti that she had a “constant ache” in her left shoulder. She also reported that during certain movements of her left arm, she felt a “catching in the left AC joint with sharp pain, with pain extending to the base of the neck and the chest.” Respondent reported that she received chiropractic care one to two times per month for her left shoulder.

42. Dr. Yashruti conducted a physical examination of respondent. Range of motion for abduction and flexion of her left arm was 180 degrees, extension 50 degrees, external rotation towards the right was 80 degrees, external rotation towards the left was 70

degrees. Adduction on the left was 15 degrees. Respondent complained of “catching in the left AC joint area.”

43. Dr. Yashruti noted in the “impression” section of his report that respondent had a “history of left shoulder impingement with adhesive capsulitis, status post three surgical procedures...with debridement, Mumford procedure and release adhesions.” Dr. Yashruti noted that the objective findings of his physical examination were that she had “minor limitation, mostly in left shoulder.” He opined that “her main problem” was the “catching in the left shoulder.” He further stated that respondent had a “palpable defect over the left AC joint, which is quite tender.”

44. Dr. Yashruti noted that respondent had “permanent work restrictions regarding the left shoulder to preclude her from repetitive movements of the left shoulder, heavy lifting, pushing and pulling and from repetitive raising of the left arm above shoulder level.”

45. There was no reference in the report prepared by Dr. Yashruti that he reviewed respondent’s written job description or the physical requirements of her position. Dr. Yashruti also did not opine as to whether respondent was permanently disabled or incapacitated from performance of her duties as a RT for the Department.

Qualified Medical Evaluations by Robert McIvor, M.D.

46. On July 5, 2012, and December 23, 2014, Dr. McIvor conducted QMEs of respondent, related to her workers compensation claim. Dr. McIvor prepared reports concerning his evaluations and testified at hearing. Dr. McIvor has practiced as an orthopedic surgeon for over 50 years. He graduated from Stanford Medical School. Dr. McIvor runs a limited private practice. The majority of the work he performs is related to workers compensation evaluations.

JULY 5, 2012 QME

47. On July 5, 2012, Dr. McIvor evaluated respondent. Dr. McIvor did not review respondent’s job duties or the physical requirements of an RT for Napa as part of the evaluation. Dr. McIvor reviewed respondent’s “extensive medical file” and provided a list of the records and reports he reviewed. Dr. McIvor obtained from respondent a history of her injury and treatment and her current complaints.

48. Respondent reported to Dr. McIvor that she had “ongoing pain and a feeling of instability involving her left shoulder.” She also reported numbness in her left hand and arm, “particularly if she tries to wear a bra with straps.” She explained that any type of strap put pressure on her left shoulder. The numbness in her hand was on the ring and little fingers. She also claimed to have weakness when she tried to grip. Lifting, carrying, pushing, pulling and holding with her left side increased her pain and numbness.

49. Dr. McIvor conducted a physical examination of respondent. He found “limited motion about the left shoulder with abduction of 120/175 degrees.” Forward flexion was “170/170 degrees.” Her internal and external rotation was not limited. He also noted “considerable pain on palpation over the acromioclavicular joint.” Dr. McIvor also conducted several tests including the Neer test which tests for impingement, the O’Brien test which tests the biceps tendon, and the Adson’s test, which checks for the strength of the pulse in the “effected arm.” A positive Adson’s test means that there is nerve compression that effects the pulse and can cause numbness in the effected arm. Respondent tested positive for the three tests. Dr. McIvor also tested respondent’s grip strength with the Jamar Dynamometer. He measured her right and left grip strength three times. The right side measured “60-60-60 pounds.” Her left side measured “44-42-40 pounds.”

50. Dr. McIvor diagnosed respondent with “impingement syndrome, left shoulder, with subsequent surgical procedures” and “thoracic outlet syndrome.”¹ At hearing, Dr. McIvor testified that impingement is friction that develops between head of humerus and rotator cuff tendons and acromion which is adjacent to head of humerus. In order to address the impingement, a surgical procedure is used to make more room to stop the friction.

51. Dr. McIvor’s objective findings were that respondent had “some restriction of abduction, but, essentially, there is excellent range of motion.” He noted that respondent had some weakness of grip. Dr. McIvor also referenced the positive findings of the Neer, O’Brian and Adson’s tests.

52. Dr. McIvor opined that respondent’s “precluded activities would involve very forceful pushing and pulling type stress on the left arm, lifting weights in excess of ten pounds, and sustained outstretched and overhead use of the left arm.” Dr. McIvor testified that respondent could “occasionally” perform the precluded activities, but these activities were “best avoided” to limit or reduce the amount of pain she was having in her left shoulder.

JANUARY 23, 2014 QME

53. On January 23, 2014, Dr. McIvor performed a second QME of respondent and prepared a report. Dr. McIvor did not review respondent’s job duties or the physical requirements of an RT for the Department as part of the evaluation.

¹ The Merriam-Webster online medical dictionary defines thoracic outlet syndrome as “any of a group of neurovascular disorders that are marked by the compression of nerves (as the brachial plexus) or blood vessels (as the subclavian artery or vein) as they pass from the neck toward the armpit or proximal arm through a space in the upper thorax between the clavicle and the first rib, that typically result in pain, numbness, weakness, or intolerance to cold, and that are usually caused by a congenital anatomical anomaly, traumatic injury, or repetitive motion of the shoulder and arm. (<http://www.merriam-webster.com/medical/thoracic%20outlet%20syndrome>.)

54. Respondent complained of “radiating pain” on her left side which caused heart and chest pain. She reported that the pain went from her neck to left ear and head, down her arm, and down her back and chest on the left side. Respondent claimed that because of the “instability” in her left shoulder and the “catching of ligaments or muscle” in the “gap” in her shoulder along with the pain and numbness, she “pretty much lost the use of her left arm at times.”

55. Respondent reported that she was working 35 hours per week as a RT and that she had to undergo a “functional evaluation study, but was not able to pass it” due to her left shoulder. Respondent was referring to a position she took as a RT with St. Joseph’s Behavioral Health Clinic (St. Joseph’s) in August 2011.

56. Dr. McIvor conducted a physical examination of respondent. He found that her left shoulder motion was “only slightly restricted with forward flexion being 160/170 degrees.” Abduction was 152/170 degrees, external and internal rotation was 70/90 degrees. Her grip strength on the right side was 60-52-52 pounds and 38-38-38 pounds on the left side.

57. Dr. McIvor diagnosed respondent with “[s]prain, left shoulder, with three subsequent surgeries.” He opined that “there has really not been any change in status since the date suggested by Dr. Weiss 6.11.07.” He further stated that the “main area of injury and concentration is the left shoulder itself.” He also noted the “positive finding for the thoracic outlet problem.” Dr. McIvor opined that the thoracic outlet problem did not significantly contribute to respondent’s impairment and that it “may be at least partially responsible for any transient numbness that she experiences in her left arm and hand.” Further, his objective findings were that respondent had a “slight restriction of motion and some weakness of grip.” She had “soreness over the acromioclavicular joint” and was “positive for the Adson’s test on the left.” Dr. McIvor opined that respondent had the same activity preclusions set forth in his July 5, 2012 report.

58. Dr. McIvor testified that during both evaluations, respondent complained that her left shoulder felt less stable. Dr. McIvor opined respondent’s feeling that her shoulder was less stable was a “subjective feeling.” Her shoulder did not dislocate and there were no objective findings to support respondent’s feeling that her shoulder was less stable.

59. Dr. McIvor evaluated respondent using the workers compensation standards. He was not aware of the standards used by CalPERS to determine if an individual is eligible for disability retirement. He did not apply the CalPERS standards or consider whether respondent was permanently disabled or incapacitated from performance of her duties as a RT for the Department, when he rendered his opinions.

Independent Medical Evaluation by Joseph Serra, M.D.

60. On March 5, 2008, at the request of CalPERS, Joseph Serra, M.D. conducted an independent orthopedic medical evaluation (IME) of respondent and thereafter prepared a

report. Dr. Serra also prepared supplemental reports dated June 1, 2011, and February 12, 2015, based on his review of additional medical records and information provided by respondent. Dr. Serra is a board-certified orthopedic surgeon. Dr. Serra operated a private practice from 1966 until 2002. He treated orthopedic patients. Dr. Serra teaches orthopedics to doctorate students in the physical therapy program at the University of Pacific. Dr. Serra contracts with CalPERS to perform IMEs.

61. As part of the IME of respondent, Dr. Serra interviewed respondent, obtained a personal and medical history, and conducted a physical examination. He also reviewed respondent's job description, the physical requirement of a RT and her medical records related to her orthopedic condition, including records from Dr. Stagg, Dr. Newman, Dr. Franzino, and Dr. Weiss.

RESPONDENT'S COMPLAINTS AND PHYSICAL EXAMINATION

62. Respondent provided Dr. Serra information about the July 19, 2003, injury she sustained to her left shoulder and a history of her treatment, including the three surgeries performed by Dr. Weiss.

63. Respondent informed Dr. Serra that she had a "dull pain in the left shoulder with intermittent numbness." She also had numbness over the scar on her left shoulder. The pain in her shoulder would "occasionally" result in tightness that radiated to her neck and the left temporal area of her head. She was unable to wear a backpack due to the pain it caused her shoulder and clavicle. She also reported chronic weakness of her left arm. Respondent informed Dr. Serra that she was "unable to open jars and would not be able to manage assaultive behavior." Respondent ranked her pain on a "good day" as a "5" out of "10." On bad days her pain is an "8-10."

64. Dr. Serra conducted a physical examination of respondent. Dr. Serra noted that she had "four scars about the deltoid and distal clavicle and posterior joint." He also noted "tenderness over the scar at the areas of the resectioned distal clavicle." Dr. Serra found no evidence of "atrophy involving the left shoulder girdle in comparison to the right."

65. Dr. Serra tested respondent's range of motion for both shoulders. Her abduction and flexion were 170 degrees bilaterally. For her internal rotation she was able to "reach to the L1 level on lift off bilaterally." Her external rotation bilaterally was 80 degrees. Her extension bilaterally was 30 degrees. Adduction was 25 degrees on the right side and 15 degrees on the left. Dr. Serra noted that respondent only complained of pain with the abduction of the left shoulder, which resulted in a "minimal pinch in the superior aspect of the left shoulder girdle." Respondent's range of motion for her elbow, forearms, wrists, and hands were "intact." Dr. Serra measured the circumference of respondent's biceps, forearm and wrist. Bilaterally the measurements were identical.

66. Dr. Serra also administered Jamar testing to determine respondent's grip strength. On three trials her right hand measured "45, 40 and 40 pounds." Her left hand measured "20, 25, and 20 pounds."

67. Dr. Serra also conducted a neurologic examination of respondent's upper extremities. Her motor function and sensation were intact. Her peripheral pulses were also intact.

IMPRESSION

68. Based on Dr. Serra's evaluation of respondent, his impressions related to respondent's orthopedic condition were:

1. Status surgery x3, left shoulder.
2. Adhesive capsulitis, left shoulder,
3. Arthritis, left acromioclavicular joint,
4. Possible anterior labral tear, left shoulder,
5. Impingement syndrome, left shoulder.

69. In response to the question posed by CalPERS to Dr. Serra concerning whether there were specific job duties that respondent was unable to perform because of a physical or mental condition, Dr. Serra answered "No." Dr. Serra also wrote:

It is my opinion that while Ms. Parker's subjective complaints may make performing certain tasks difficult by causing some pain or discomfort, there are not sufficient abnormal physical findings that support her subjective complaints, or that suggest that she would be unable to perform her usual and customary work activities.

He further opined that respondent was not incapacitated from the performance of her usual duties as an RT. At hearing, Dr. Serra opined that there were no job duties respondent could not perform due to her orthopedic condition. He explained that some duties may be uncomfortable for respondent or cause her pain, but with her strength and range of motion, she could perform all of her duties of an RT, including MAB.

JUNE 1, 2011 SUPPLEMENTAL REPORT

70. On May 16, 2011, CalPERS sent Dr. Serra two pages of written information from respondent, the QME report from Dr. Yashruti, the orthopedic consultation by Dr. Dainer and records from James F. Hayes, D.C., a chiropractor who treated respondent.

71. None of the information submitted to Dr. Serra changed his opinion as set forth in his March 14, 2008 report. Dr. Serra noted that the two pages of written information from respondent discussed the requirement that she perform MAB when she worked as a RT for the Department. Dr. Serra opined that from an orthopedic standpoint, respondent was capable for performing MAB.

FEBRUARY 12, 2015 SUPPLEMENTAL REPORT

72. On January 29, 2015, CalPERS sent Dr. Serra additional information from respondent concerning her on-going medical care, including the QME reports issued by Dr. McIvor. None of the information submitted to Dr. Serra changed his opinions set forth in his March 14, 2008, or June 1, 2011 reports. Dr. Serra determined that there was no new information concerning respondent's orthopedic condition contained the reports. Dr. Serra also disagreed with the activity restrictions recommended by Dr. McIvor. Dr. Serra opined that there is a different standard applied when an evaluator conducts a QME, versus an IME. Dr. Serra explained that a QME evaluator, as was the case with Dr. McIvor, will often recommend prophylactic restrictions on an individual's activities to prevent further injury, without addressing whether the individual is incapacitated from performance the usual and customary duties. Dr. Serra opined that the restrictions were based upon subjective complaints made by respondent concerning her condition. Dr. Serra opined that from an objective standpoint, respondent was capable of performing her duties as a RT.

Respondent's Testimony and Additional Evidence

73. After respondent's shoulder injury on July 19, 2003, her shoulder pain became more "acute" over time. Respondent had a difficult time pushing and pulling the wheelchairs at Sonoma. Respondent sought treatment with Dr. Staggs in February 2004, one month before she transferred to Napa. Respondent was aware when she transferred to Napa that she was required to conduct MAB. She and other staff at Napa utilized MAB on patients that would "lose control" or become aggressive. When this occurred, a team of staff would restrain the patient so no one was harmed. Respondent had engaged in MAB one to three times per day. Respondent contended that she was "unofficially" not required to perform MAB due to her shoulder condition. Once the Department received the "permanent and stationary report" that precluded her from performing MAB, she was told that she did not qualify for her position because the performance of MAB was a requirement of her position.

74. Since August 22, 2011, respondent has worked as an RT for St. Joseph's. The job is similar to her position at Napa. Respondent was required to complete "Functional Activity Tests" before she was hired at St. Joseph's. Respondent's physical abilities were tested in a number of ways, including her grip strength, her ability to push and pull with one arm at a time and at shoulder height. Her range of motion was also tested, include her ability to "reach forward, to bend and rotate in the neck and trunk when helping to restrain a patient" and to "reach forward, to attain and sustain a kneeling position when helping to restrain a patient." Respondent was able to meet or exceed all of the tested requirements, with the exception of the bilateral shoulder height pull, which tested her "pulling force with

both arms when helping to restrain a patient.” Respondent was required to pull 100 pounds. She was able to pull 77.2 pounds. Respondent’s bilateral grip strength revealed “no significant defects.” Her range of motion testing exceeded the requirements by over 30 percent. The evaluator noted that respondent denied “any musculoskeletal discomfort during the testing.”

75. Respondent testified that she was hired at St. Joseph’s despite her inability to pull 100 pounds. Upon hire, she was given a reasonable accommodation which precludes her from performing MAB, due to the “weakness in her shoulder.”

Discussion

76. When all the evidence is considered, Dr. Serra’s opinion that respondent is not permanently disabled or incapacitated for the performance of her duties as a RT for the Department, based upon her orthopedic condition is persuasive. Dr. Serra based his opinion on his review of respondent’s job description, the physical requirements of her job, review of her medical records and a physical examination. The physical examination he conducted revealed that respondent has excellent range of motion in her shoulder. The functional activity tests respondent performed at St. Joseph’s on August 11, 2011, further buttressed Dr. Serra’s opinion that respondent was not substantially disabled or incapacitated from the performance of her duties as a RT. Respondent was able to meet or exceed almost all of the tested areas, with the exception of the shoulder height pull. In that case, she was able to pull 77.2 pounds. As set forth in the Physical Requirements for respondent signed on March 15, 2007, she never lifted more than 50 pounds when she worked as a RT for Napa. In addition, while respondent may experience pain or discomfort when she engages in certain activities, such as MAB, the evidence established that she is capable of performing her duties as a RT, including MAB.

77. Dr. McIvor’s opinion that respondent cannot perform MAB or the duties of a RT, is not supported by the evidence. First, Dr. McIvor failed to review respondent’s duties as a RT for the Department, or the Physical Requirements form for the position when rendered his opinions. Furthermore, the activity restrictions recommended by Dr. McIvor are designed to limit or reduce the amount of pain she was having in her left shoulder. The restrictions were not based on an inability to perform the activities or any current disability.

In addition, respondent’s contention that her left shoulder is “less stable” was a subjective feeling, not supported by objective findings. Dr. McIvor acknowledged that respondent’s shoulder did not dislocate and there were no objective findings to support respondent’s feeling that her shoulder was less stable. Finally, Dr. McIvor evaluated respondent using the workers compensation standards. He did not apply or consider whether respondent was permanently disabled or incapacitated from performance of her duties as a RT for the Department.

78. Additionally, none of the medical records that respondent submitted contradict Dr. Serra’s opinion that respondent is not permanently disabled or incapacitated for the

performance of her duties as a RT. There is no indication in the records that any of the doctors determined that respondent was permanently disabled or incapacitated from performance of her duties as an RT for the Department, based on her orthopedic condition.

79. Respondent failed to present competent medical evidence to support her assertion that she is permanently disabled or incapacitated for the performance of her usual duties as a RT based upon the legal criteria applicable in this matter. Consequently, respondent failed to establish that her industrial disability retirement application should be granted based upon her orthopedic condition.

LEGAL CONCLUSIONS

1. Respondent seeks disability retirement pursuant to Government Code section 21151, subdivision (a), which provides in pertinent part, that “[a]ny patrol, state safety, state industrial, state peace officer/firefighter, or local safety member incapacitated for the performance of duty as the result of an industrial disability shall be retired for disability, pursuant to this chapter, regardless of age or amount of service.”

2. To qualify for disability retirement, respondent must prove that, at the time she applied, she was “incapacitated physically or mentally for the performance of his or her duties...” (Gov. Code, § 21156, subd. (a)(1).) As defined in Government Code section 20026,

“Disability” and “incapacity for performance of duty” as a basis of retirement, mean disability of permanent or extended and uncertain duration, as determined by the board ... on the basis of competent medical opinion.

3. In *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876, the court interpreted the term “incapacity for performance of duty” as used in Government Code section 20026 (formerly section 21022) to mean “the *substantial* inability of the applicant to perform his usual duties.” (Italics in original.) The employee in *Mansperger* was a game warden with peace officer status. His duties included patrolling specified areas to prevent violations and apprehend violators, issuing warnings and serving citations, and serving warrants and making arrests. He suffered an injury to his right arm while arresting a suspect. He could shoot a gun, drive a car, swim, row a boat, pick up a bucket of clams, pilot a boat, and apprehend. However he could not lift heavy weights or carry a prisoner away. The court noted that “although the need for physical arrests do occur in petitioner’s job, they are not a common occurrence for a fish and game warden.” (*Mansperger, supra*, 6 Cal.App.3d at p. 877.) Similarly, the need for him to lift a heavy object alone was determined to be a remote occurrence. (*Ibid.*) In holding that the game warden was not incapacitated for the performance of his duties, the *Mansperger* court noted that the activities he was unable to perform were not common occurrences and that he could otherwise “substantially carry out the normal duties of a fish and game warden.” (*Id.* at p. 876.)

4. The court in *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 855, reached a similar conclusion with respect to a state traffic sergeant employed by the CHP. The applicant in *Hosford* had suffered injuries to his left ankle and knee, and had strained his back. The court noted that the sergeant “could sit for long periods of time but it would ‘probably bother his back;’ that he could run but not very adequately and that he would probably limp if he had to run because he had a bad ankle; that he could apprehend persons escaping on foot over rough terrain or around and over obstacles but he would have difficulty and he might hurt his back; and that he could make physical effort from the sedentary state but he would have to limber up a bit.” (*Id.* at p. 862.) Following *Mansperger*, the court in *Hosford* found that the sergeant:

is not disabled unless he is substantially unable to perform the usual duties of the job. The fact that sitting for long periods of time in a patrol car would “probably hurt his back,” does not mean that in fact he cannot so sit; ...[¶] As for the more strenuous activities, [a doctor] testified that Hosford could run, and could apprehend a person escaping over rough terrain. Physical abilities differ, even for officers without previous injuries. The rarity of the necessity for such strenuous activity, coupled with the fact that Hosford could actually perform the function, renders [the doctor’s conclusion that Hosford was not disabled] well within reason. (*Ibid.*)

In *Hosford*, the sergeant argued that his condition increased his chances for further injury. The court rejected this argument, explaining that “this assertion does little more than demonstrate that his claimed disability is only prospective (and speculative), not presently existing.” (*Hosford, supra*, 77 Cal.App.3d at p. 863.) As the court explained, prophylactic restrictions that are imposed to prevent the risk of future injury or harm are not sufficient to support a finding of disability; a disability must be currently existing and not prospective in nature. (*Ibid.*)

5. In *Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697, the court determined that a deputy sheriff was not permanently incapacitated for the performance of his duties, finding, “A review of the physician’s reports reflects that aside for a demonstrable mild degenerative change of the lower lumbar spine at the L-5 level, the diagnosis and prognosis for the appellant’s condition are dependent on his subjective symptoms.”

6. The burden of proof is on respondent to demonstrate that she is permanently and substantially unable to perform her usual duties such that she is permanently disabled. (*Harmon v. Board of Retirement of San Mateo County, supra*, 62 Cal. App. 3d 689; *Glover v. Board of Retirement* (1980) 214 Cal. App. 3d 1327, 1332.) To meet this burden, respondent must submit competent, objective medical evidence to establish that, at the time of her application she was permanently disabled or incapacitated from performing the usual duties of her position. (See *Harmon v. Board of Retirement, supra*, 62 Cal.App.3d at 697.)

7. When all the evidence in is considered in light of the courts' holdings in *Mansperger*, *Hosford*, and *Harmon*, respondent did not establish that her industrial disability retirement application should be granted. Although respondent had subjective complaints of pain and a feeling that her shoulder less stable, there was not competent, objective medical evidence that she was permanently disabled or incapacitated for the performance of the usual duties of her job as a RT, based on her orthopedic condition. Consequently, her industrial disability retirement application must be denied.

ORDER

Respondent Karen Parker's application for industrial disability retirement is DENIED.

DATED: April 18, 2016

DocuSigned by:
Marcie Larson
F72F4885838541C

MARCIE LARSON
Administrative Law Judge
Office of Administrative Hearings