

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 (Statement of Issues)
of:

WENDY MACY (LUCAS),

Respondent,

and

CALIFORNIA DEPARTMENT OF
CORRECTIONS AND REHABILITATION,
CENTRAL CALIFORNIA WOMENS
FACILITY,

Respondents.

Case No. 2014-1153

OAH No. 2015010255

PROPOSED DECISION

Administrative Law Judge Stephen J. Smith (ALJ), Office of Administrative Hearings, (OAH) State of California heard this matter in Fresno, California, on May 3, 2016.

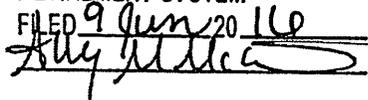
Elizabeth Yelland, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Wendy Macy, now known as Wendy Lucas (applicant) appeared and was represented by Robert E. Szkowny, Attorney at Law, of Weinberg, Roger and Rosenfeld, Attorneys.

Respondent California Department of Corrections and Rehabilitation, Central California Women's Facility, did not appear.

Evidence was taken, the matter was argued. The record was closed and the matter was submitted for Decision on May 3, 2016.

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM

FILED 9 Jun 20 16


ISSUES

Is applicant substantially incapacitated from her usual and customary duties as an Office Technician (OT) with the CDCR at the Central California Women's Facility (CCWF) as a result of the orthopedic condition of her low back, her rheumatologic condition, or a combination of these?

If applicant is substantially incapacitated, is applicant's incapacity the product of an injury, disease or condition arising out of, connected with, or caused by her work with CDCR CCWF?

If applicant is substantially incapacitated, is her incapacity permanent, in the sense of being expected to continue indefinitely?

Should applicant's claim for IDR be expanded to include conditions not included in her application claim, including chronic obstructive pulmonary disease (COPD), psychiatric disability including posttraumatic stress disorder (PTSD) and/or rheumatoid arthritis?

Can applicant's claim for IDR be considered as an overall cumulative illnesses/conditions trauma claim leading to substantial incapacity, considering the collective effect of the conditions and illnesses applicant claimed in her application, as well as the conditions not included in her application but listed just above?

SUMMARY OF RESOLUTION OF ISSUES

Applicant failed to prove by a preponderance of the evidence that she is substantially incapacitated from the performance of her usual and customary duties as an OT at CDCR CCWF due to the condition of her back and her rheumatologic condition. Applicant failed to present persuasive medical evidence that any or all of the conditions she advanced as causes for her claimed incapacity caused her to be substantially incapacitated from the performance of her clerical/administrative usual and customary duties at CDCR CCWF. Applicant failed to prove any incapacity she suffers, as a reasonable medical probability, will extend indefinitely. Applicant failed to prove that any incapacity she suffers arose out of or was caused by her employment, and thus applicant's conditions and illnesses were not proved to be industrially caused.

FACTUAL FINDINGS

Procedural and Jurisdictional Findings

1. Applicant was employed by CDCR as an OT, assigned to CCWF at all times relevant to this Decision. Applicant has been and remains a state industrial member of CalPERS.

2. Applicant applied to CalPERS for an industrial disability retirement (IDR) on December 9, 2013. The application was received by CalPERS on December 30, 2013. Applicant had the minimum service credits to qualify for a service retirement at the time of her application.

3. Applicant claimed in her IDR application that she is disabled and unable to perform her duties as an OT for CDCR because of fibromyalgia, chronic pain, chronic back pain, "DJD," and osteoarthritis. Applicant stated the disability occurred on June 29, 2012.

4. Applicant stated that her disabilities occurred as a result of an ongoing process over a period of time, rendering her unable to function due to pain and mobility impairment. Applicant stated her limitations and preclusions due to her disability include her inability to sit/stand/walk for long periods. She also stated her bones and joints hurt, that she is unable to lift/hold/manipulate objects. She is unable to concentrate and needs to take strong medication for pain that feels like bee stings/stabbing/cutting.

5. Applicant stated that her disability has affected her ability to perform her job because she has severe pain, making her unable to walk, lift, hold things, open doors, and concentrate. She also noted she has extreme fatigue. She stated she is not currently working in any capacity.

6. Applicant wrote in the section, "Other information you would like to provide," that her quality of life has been very diminished as a result of her condition. She noted she is unable to do basic things in my home/daily life.

7. Applicant advised in her application her treating physicians were Dr. Chen of Fresno, CA for primary care and Dr. Akbar for management of her chronic pain. Applicant submitted medical records and other documentation in response to the request of CalPERS's Benefits Services Division (BSD). These medical records were from health care practitioners treating or evaluating applicant in conjunction with her Workers Compensation claim, and her personal physicians. Applicant submitted, among others, records from Mitchell Fung, M.D., K. Akbar, M.D., Kenneth Bernstein, M.D., and Nicholas Nomicos, M.D., as well as records from Kaiser Permanente, Camarena Health and Madera County Behavioral Health Services.

8. Applicant's medical and other records were received by the staff of CalPERS' BSD and forwarded for review and consideration to Ghol Ha'Eri, M.D., a Board certified orthopedic surgeon retained by CalPERS to perform an orthopedic Independent Medical Evaluation (IME), and to Douglas M. Haselwood, M.D, a Board certified Rheumatologist, to perform a rheumatology IME.

9. CalPERS' BSD staff received the IME reports from Dr. Ha'Eri and Dr. Haselwood and reviewed them, in addition to all the other medical and other records received. CalPERS BSD staff concluded the medical and other information did not support granting the application. CalPERS's BSD notified applicant in writing on July 23, 2014, that

her application was denied because she had failed to produce sufficient persuasive medical evidence to demonstrate that she was substantially incapacitated from her duties as an OT with the CDCR as a result of any of the disabling injuries, illnesses or conditions she identified in her application. CalPERS BSD also advised applicant that any disability she experienced did not appear to have been the product of, or arose out of her work for CDCR. CalPERS BSD staff primarily relied upon the IME reports of Dr. Ha'Eri and Dr. Haslewood in making the determination to deny the application.

10. The CalPERS BSD denial notice to applicant advised her of her right to appeal the denial, and of her right to have an evidentiary hearing before an independent ALJ to review the basis for the denial. Applicant timely appealed.

11. Anthony Suine, Chief of CalPERS' BSD, made the allegations in the Statement of Issues in his official capacity only. The Statement of Issues was filed and served on applicant on December 3, 2014.

12. Applicant timely filed a Request for Hearing on the Statement of Issues. The matter was set for an evidentiary hearing before the ALJ, and this hearing followed.

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

Substantive Factual Findings

USUAL AND CUSTOMARY DUTIES

14. Applicant's official CDCR Duty Statement describes her position as OT (Typing) Triage and Treatment Area, a job where the incumbent functions under the general direction of the Supervising Registered Nurse for the Triage and Treatment area. The OT provides clerical support to Nursing Services, and requires, "a high level of clerical skills, initiative, independence of action and good judgment."

Applicant's Duty Statement states:

DUTIES:

35% Type reports, letters and memorandums as assigned. Log, route and track documents requiring a signature approval. Independently, or with minimal direction, compose correspondence, meeting notices, reports and general requests for healthcare program information using Department approved software programs. Create and maintain an assignment log, input staff person assigned a project due date, follow-up on

overdue assignments. Edit outgoing correspondence prepared by nursing staff, ensure consistency with administrative policy as well as format, grammar and construction, adherence to Department policies, and work with author to make necessary corrections. Maintain a chronological file of all incoming and outgoing correspondence.

30% Answer telephones, take messages, fax, photocopy, process incoming and outgoing mail, arrange for material to be duplicated and act as a courier. Prepare and update nursing staff schedule. At the request of the Supervising Registered Nurse, phone the medical services contract vendor to obtain staff to fill behind institution vacancies on a temporary basis. Develop and maintain a filing system that allows for easy retrieval of documents.

20% Attend meetings and take meeting minutes, arrange for meeting space using Outlook, send out meeting requests, set up conference calls as needed, duplicate handouts and agenda. Provide administrative report, i.e., arrange for ground and air transportation and lodging. Prepare and submit travel advances and travel reimbursement claims. Work with accounting to rectify any problems.

10% Collect, audit and maintain timesheets for staff supervised by the supervising registered nurse. Liaison with headquarters regarding personnel and timekeeping issues. Maintain and update the daily calendar for the Supervising Registered Nurse. Backup other office support staff as needed. Order and maintain office supplies for assigned staff. Assist and train new support staff. Other duties as required.

CALPERS PHYSICAL REQUIREMENTS STATEMENT

15. A CalPERS Physical Requirements of Position document (Physical Requirements) for applicant's position as an OT working for CDCR at CCWF is found in Exhibit 13. The Physical Requirements description was completed with applicant's cooperation and input, and she and a CDCR Institutional Return To Work Coordinator signed the document on December 11, 2013.

16. Applicant agreed that none of the activities listed on the physical requirements document were engaged in "constantly" (over six hours per workday). Applicant agreed she engaged in the following activities at work "frequently" (3 to 6 hours per day): sitting, reaching above the shoulder, reaching below the shoulder, repetitive use of her hands, keyboard use and mouse use. Activities engaged in "occasionally" (up to three hours per

day) included: standing, walking, kneeling, squatting, bending at the neck, bending at the waist, twisting at the neck and waist, pushing and pulling, fine manipulation, power and simple grasping, lifting between zero and 25 pounds, and exposure to extreme temperature, humidity or wetness. Applicant agreed that she never engaged in the following activities at work: running, crawling, climbing, lifting anything over 25 pounds, walking on uneven ground, driving, working with heavy equipment, exposure to excessive noise, exposure to dust, gas, fumes or chemicals, working at heights, operation of foot controls or repetitive movement, use of special visual or auditory protective equipment, and working with bio hazards.

USUAL AND CUSTOMARY DUTIES-ACTUAL

17. Applicant agreed in her testimony that her Duty Statement and the CalPERS Physical Requirements statement regarding her position as she actually performed it at CCWF is reasonably accurate in a general sense. Applicant agreed that her position is primarily sedentary, but did require a good deal of walking back and forth from her workstation to the various inmate housing areas where the nursing services were performed. She also pointed out that she worked the night shift, so she almost never had any inmate assistance, as she would have had she worked on the day shift. She pointed out that the CDCR CCWF Duty Statement is a broad and general description of the job that includes both day and night shifts.

18. Applicant described her job and workplace as "busy". She testified she walks approximately a half mile per day going back and forth for files and to retrieve and access reports, and to retrieve and deliver mail. She testified she performed, "lots of typing," preparing files for doctors and nurses, and making sure that she keyed patient information and medical information obtained from the doctors and nurses into inmate patient records accurately and carefully. She also chaperoned male nurses for exams of female inmates. She sorted and moved a large amount of mail. She answered phones, contacted the watch commander, and called the ambulance for emergencies, which seemed like a frequent event. Applicant noted that alarms go off often. Each nurse and doctor carry a personal alarm, and when those alarms go off, she has to assist in making sure that backup and support are obtained.

19. Applicant testified that her illnesses and conditions have made her very sensitive to noise and stress, and both are found in abundance in her workplace at CDCR CCWF. She even commented during her testimony that the court reporter's stenotype sounded loud to her. The alarms each night in the prison stress her. She is very concerned about her cognition and ability to make accurate clerical transcription of nurses' and doctors' notes in inmate patient charts, a primary job function. Between the medications she takes for her conditions, her chronic pain, and panic attacks from her PTSD that followed her late 2012 car accident, she is very concerned that she does not think like she used to, and the chances of her making a terrible mistake in a patient medical record have greatly increased. "I cannot think straight when I get lots of papers from so many people, I get overwhelmed." "When I am under pressure, I collapse and retreat to my safe place in my home." "I cannot

even take my dogs out for a walk anymore.” Applicant is convinced that a combination of her memory and cognitive deficits due to her conditions and the medication she is required to take make her unsafe to perform her job as it is required at CCWF. She is convinced that if she returns to work she will make an error that could likely result in great harm to an inmate patient.

APPLICANT’S TESTIMONY

20. Applicant’s occupational history is vague. From what little information exists in the record, it appears that applicant was hired to work as a clerical support for the nursing staff at CDCR CCWF in October or November 2005. Applicant’s last day of work was June 29, 2012. It appears that applicant worked for CDCR for approximately six years and six months. There is no information in the record regarding applicant’s work performance or work history. There is no evidence in the record from applicant’s workplace or supervisors reflecting any inability, incapacity, or insufficiency in applicant’s work performance as a result of any or all of the conditions and illnesses of which she complains. There is no evidence in this record of any discrete injury or incident that occurred at work that caused all or any part of applicant’s claimed conditions, injuries and illnesses. Applicant has made no claim that anything that occurred to her at work, or any interaction with any person at work, caused or contributed to the conditions she claims disable her.

21. Applicant’s testimony focused almost exclusively upon her physical and emotional conditions and the manner in which those conditions prevent her from being able to perform even the most basic tasks of daily living, much less her work duties. Applicant described having back pain of a constant nature of a mild to moderate intensity since age 26, when she was pregnant. Applicant once enjoyed horseback riding, and has taken several falls, which contributed to her low back pain. Applicant acknowledged that her back pain problem began years before she started work with CDCR CCWF.

22. Applicant described a “relentless” advance of her low back pain when she was in her 30s. She was evaluated by several healthcare providers including neurologists, and began a pain management treatment program, which she continues to date.

23. Applicant described increasingly more persistent and bothersome widespread musculoskeletal pain when she got into her 40s. She described pain and spasms in conjunction with other health problems she had, such as chronic obstructive pulmonary disease (COPD) and posttraumatic stress disorder (PTSD) that she got as a result of an auto accident in late 2012. Applicant claimed that as a result of the auto accident, she started having panic attacks and was diagnosed with PTSD. Due to her PTSD, her fibromyalgia, and her constantly increasing back pain, she was “in constant agony,” to the point where she could not function by June 2012, when she quit.

PRESENT STATUS

24. Applicant has not worked since June 2012, almost four years. Applicant was described by her counsel in closing argument as “a very sick woman,” as of the date of the evidentiary hearing. She presented herself as badly broken mentally, physically and emotionally, largely agoraphobic, housebound, lacking interest in much of anything beyond watching television, avoidant of gatherings of people or public places, unable to even enjoy the simple pleasure of walking her dogs. She leaves her home and her property “only when I have to.” Applicant appeared in her presentation at the evidentiary hearing slightly agitated and fidgety, moderately distressed and in some measure of discomfort, able to manage providing bare-bones testimony, but not much more. Applicant clearly has a number of problems, not the least of which is her COPD and what appears to be the possibility a recent indication that she may be suffering from rheumatoid arthritis.

25. Applicant’s medical records reveal that she is a long time cigarette smoker, and she confirmed in her testimony that she is taking some rather addictive opioids and hypnotics, all of which have significant side effects, and most of which have significant addiction/dependency and rebound effect potentials. Applicant’s current medications, which she has been taking continuously since mid-2012, include using a fentanyl patch, oxycodone, diazepam, 350 mg dose of Soma, amlodipine, and Pravastatin. It would be little short of miraculous if applicant felt well under the influence of daily doses of such heavy opioids and hypnotics. Remarkable is the fact that she is being administered fentanyl patch and oxycodone simultaneously, at the same time as taking diazepam and Soma, and even more significant, is that she has been taking this combination of addictive substances for several continuous years. Yet continuously taking all these pain killers and anxiolytics have not reduced her claims of pain and its profound limitations on her activities of daily living, nor have they made her less anxious. Applicant also appeared to be somewhat histrionic and overstated in her appearance, sometimes responding to what appeared to be internal stimuli, very much a captive and self-absorbed by how she feels at any given time. She appeared to invest effort in appearing to present herself in the worst possible light.

APPLICANT’S MEDICAL EVIDENCE

26. Applicant’s medical evidence in support of her claims is contained in packets of records from Kaiser Permanente and Camarena Health. These records were fully reviewed by Dr. Ha’Eri and Dr. Haslewood in the performance of their IMEs. There is no Agreed Medical Examination (AME) or Qualified Medical Examination (QME) of applicant in the record. The two IMEs obtained by CalPERS are the only detailed medical evaluations of applicant relative to her claims of illness, injury or condition that prevents her from being able to perform her usual and customary duties as an OT for CDCR CCWF.

KAISER PERMANENTE

27. The primary contribution to applicant’s medical evidence contained in the medical records from Kaiser Permanente are the MRI diagnostic imaging studies of her

cervical and lumbar spine. There are several such MRI images and evaluations obtained by Kaiser in pursuit of an understanding of any orthopedic or neurological causes of applicant's widely varied and significant complaints of back pain and disability. These imaging studies, as pointed out primarily by Dr. Ha'Eri (below) in his IME report, show normal age-related degenerative changes, worse in her cervical spine area, where she does not complain of symptoms, than in her lumbosacral area, where she complains of intense symptoms.

DR. AKBAR-PAIN MANAGEMENT

28. Applicant saw Dr. Akbar for pain management assessment and treatment. There are records of applicant seeing Dr. Akbar seven times between December 2007 and June 2012. Dr. Akbar completed a Physician's Report on Disability for CalPERS (Physician's Report) dated April 3, 2013.

29. Dr. Akbar diagnosed applicant as suffering from chronic low back pain, cervical spine pain, chronic, more than three months, cervical disc degeneration, fibromyalgia, and myofascial pain syndrome. Applicant told Dr. Akbar during an office visit on December 13, 2012, that even though she was still in "a lot of pain," the fentanyl patch and occasionally taking Percocet helped. Dr. Akbar noted that applicant's activities of daily living were limited due to pain. Dr. Akbar noted on physical exam that applicant had mild-moderate tenderness "over tender points of fibromyalgia" on her right arm, left arm, right leg, and left leg. He concluded that applicant has been off work one year, and "likely is disabled for long time."

30. Dr. Akbar met with applicant on January 27, 2014, noting that he, "called back to patient regarding completion of disability forms from CalPERS." Dr. Akbar noted in his chart detail for the visit that he went over details about "continued pain, reports gotten worse, and unable to sit or stand more than 10 minutes, needs to change positions, difficulty using hands, feels her mental faculties are intact, and has not worked since June 29, 2012."

31. Dr. Akbar's Physician's Report for CalPERS noted a primary diagnosis of fibromyalgia and a secondary diagnosis of myofascial pain syndrome associated with moderate tenderness. Dr. Akbar failed to fill in any of the member incapacity information on the form regarding applicant's vocational functional capabilities. Dr. Haslewood pointed out in his IME report and supplements that Dr. Akbar did not document any musculoskeletal, pathophysiological or physical impairment that would preclude applicant from sedentary job activities, and noted that Dr. Akbar left the portion of the report entitled "member incapacity" blank.

32. Applicant saw Dr. Chen as her primary care physician between December 2007 and September 2012. Dr. Chen's records provide little analytical or clinical evidence in support of any of applicant's claims.

33. Applicant saw Dr. Huang for pain management care on three occasions between January 2008 and April 2009. Dr. Huang treated applicant based upon carried

diagnoses of lumbosacral degenerative disc disease and facet and sacroiliac arthropathy, as well as piriformis muscle syndrome and myofascial pain syndrome. Dr. Huang treated applicant with steroid injections. Applicant experienced short-term relief from the steroid injections. Dr. Huang's records provide almost no clinical analysis or evaluation leading to the diagnoses upon which he treated applicant. The diagnoses appear to have come from Dr. Akbar, and were carried and followed, rather than reassessed by Dr. Huang.

CAMARENA HEALTH

34. Applicant began treatment with Nicholas Nomicos, M.D., and occasionally Kenneth Bernstein, M.D., at Camarena Health, after applicant lost her Kaiser health insurance upon resigning her position at CCWF. Dr. Nomicos is a primary care physician. Dr. Nomicos first saw applicant on November 1, 2013. Dr. Nomicos found neck tenderness on examination. Dr. Nomicos diagnosed applicant as having osteoarthritis, neck strain, chronic strained lumbosacral ligament, and fibromyalgia.

35. Applicant continued to see Dr. Nomicos through 2015, when records cease, although it appears that applicant is still being treated by him. Dr. Nomicos monitored applicant's general health issues, but especially musculoskeletal complaints attributed primarily to degenerative and mechanical musculoskeletal problems. Dr. Nomicos' clinical notes for his examinations of applicant contain no documentation of any substantial musculoskeletal abnormality or impairment.

36. The focus of applicant's treatment with Dr. Nomicos changed slightly in mid-2014, continuing through 2015, to focusing on musculoskeletal pain. Dr. Nomicos attributed applicant's pain to osteoarthritis and fibromyalgia. Dr. Nomicos found applicant had tenderness in her large joints, loss of motion and some swelling in her wrists, hips and knees. There is no documentation in any of Dr. Nomicos' clinical records or chart notes describing any musculoskeletal abnormality associated with an active synovitis (an active or evidently emerging arthritic inflammatory process in a joint or joints).

37. Dr. Nomicos' office visit of April 13, 2015, was noteworthy in that laboratory results were obtained showing indications of a potential occult or emerging rheumatoid arthritis. Dr. Nomicos added a diagnosis of rheumatoid arthritis to fibromyalgia, but his records and chart notes do not disclose any specific workup or diagnostic evaluation to support a diagnosis of rheumatoid arthritis. The diagnosis stands as entirely conclusory, based only on the indications in the laboratory results. Dr. Nomicos' clinical evaluation and examination described abnormalities at applicant's hips and knees, but did not specifically identify any evidence of evolving or active synovitis.

38. Applicant's treatment with Dr. Nomicos continued through 2015, focusing on musculoskeletal pain attributed to arthritis and other mechanical musculoskeletal problems. Clinical examination notes described applicant having swelling and tenderness variably in her shoulders, knees, and hips, but no description of an active synovitis.

39. Dr. Nomicos' last office visit chart note in this record was for a follow-up in July 2015 for refilling arthritis pain medication. Dr. Nomicos' diagnosis at that time was chronic strain lumbosacral ligament, lumbar disc degeneration, lumbar radiculopathy and sciatica, musculoskeletal tenderness in the thoracic and lumbar region only. No diagnostic assessment for rheumatoid arthritis was ever made.

CALPERS MEDICAL EVIDENCE

ORTHOPEDIC-DR. HA'ERI'S IME

40. Ghol Ha'Eri, M.D., is a Board-certified Orthopedic Surgeon retained by CalPERS to perform an IME in orthopedics of applicant. Dr. Ha'Eri performed his IME on May 17, 2014, and wrote a report of his findings. Dr. Ha'Eri also wrote a very brief Supplemental IME report, dated June 23, 2015. This Supplemental IME report was submitted in response to a CalPERS request that Dr. Ha'Eri review and comment whether his original opinions would be changed after reading additional medical records and reports from Dr. Chen, Dr. Akbar, Dr. Huang, Dr. Nomicos, and diagnostic imaging, physical and occupational therapy reports.

DR. HA'ERI'S IME FINDINGS AND CONCLUSIONS

41. Dr. Ha'Eri noted in his IME report that applicant was being evaluated for her constant lower back pain of a mild to slight intensity, on a scale of 0 to 10 applicant reported a maximum of six. Applicant's lower back pain radiated to her left buttock and leg, associated with a tingling sensation and numbness. Applicant also complained of muscle tightness in her lower back. There were no reportable symptoms or complaints about her cervical spine.

42. Dr. Ha'Eri noted on his orthopedic physical examination that applicant is slightly built with normal posture and gait. He noted that she did not use any assistive device for ambulation, did not wear a back brace and did not appear to be in any acute distress. Dr. Ha'Eri's visual examination of applicant's lower back revealed a normal lumbar lordosis, the curvature of the spine. He found slight tenderness when he palpated her lumbar sacral region, with tenderness extending into her left buttocks. He found no evidence of muscle spasm.

43. Dr. Ha'Eri found limited range of motion in applicant's lumbar spine in flexion, extension, lateral bending and lateral rotation. Only slight limitation was found with a straight leg raise on the left leg. Straight leg raise of the right leg was normal. Dr. Ha'Eri's neurological evaluation of applicant's lower extremities was normal. Motor power in the lower extremities was normal and no atrophy was observed in either of the lower extremities. Applicant's deep tendon reflexes were present and symmetrical on both lower extremities.

44. Dr. Ha'Eri's impression following his IME was that applicant had: 1. Mild degenerative disc disease of her cervical spine; 2. Mild facet arthropathy at L5-S1; and 3.

Fibromyalgia and myofascial pain syndrome per Dr. Ha'Eri's review of the medical records that were submitted for evaluation along with his examination.

45. Dr. Ha'Eri opined that there were no specific job duties that applicant is unable to perform because of an orthopedic physical condition. He concluded that applicant has minimal degenerative changes in her cervical and lumbar spine per MRI studies, which are compatible with her age. Dr. Ha'Eri concluded that applicant is not disabled as a result of any orthopedic condition, and that the orthopedic condition of her low back would look the same at the time of his examination regardless of whether she had worked as an OT for CDCR.

46. Dr. Ha'Eri's supplemental IME report added little. Dr. Ha'Eri was asked to review the medical records from Dr. Chen from Kaiser Permanente General Medicine Department, those of Dr. Akbar from Kaiser's Physical Medicine and Rehabilitation Department, Kaiser, Dr. Pellegrino, an Orthopedic Surgeon at Kaiser, and Dr. Huang, a Kaiser Pain Management specialist. Dr. Ha'Eri also reviewed records of occupational therapy for applicant's hand, physical therapy records and diagnostic studies, including three MRIs of applicant's lumbar and cervical spine, and one of her left shoulder. Dr. Ha'Eri found nothing in these records that caused him to change his opinions reflected above.

DR. HA'ERI'S TESTIMONY

47. Dr. Ha'Eri reiterated his IME report opinions in his testimony. Dr. Ha'Eri explained that he had applicant fill out a 10 page questionnaire before he began his examination, in which, among other things, applicant disclosed the number and types of medications that she was taking at the time. Dr. Ha'Eri focused his examination on applicant's long-standing low back pain problem and complaints. He noted that applicant had seen a number of doctors for her low back pain and fibromyalgia, had undergone trigger point injections and nerve blocks for low back pain, and told him at the beginning of the examination that she was in "constant mild to moderate low back pain."

48. Dr. Ha'Eri noted that applicant's displayed normal posture and gait, without being in any acute distress, during his clinical evaluation. He noted she was not wearing or using a back brace or using a cane. He found she had a normal lordosis, meaning she showed a mild normal curvature of the low back and spine, without any evidence of flattening or spasm. These observations all signified to Dr. Ha'Eri that applicant had not suffered any significant low back injury that could explain her complaints of pain. Dr. Ha'Eri noted that he felt no spasm on palpation, even though applicant said that it hurts and she was tender to his touch.

49. Dr. Ha'Eri explained applicant's limitations on range of motion when he had applicant bend forward, backwards, and to each side with her knees straight. He observed that these tests are entirely subjective and voluntarily controlled by the patient. The test stops where the patient says it hurts. Her leg raises were fully normal with the right leg and almost normal with the left, indicating no sciatic nerve involvement. His neurological

examination showed all of applicant's sensory mechanisms were grossly intact. Her motor power, tested by having her lift on her toes and on her heels, was normal. Her reflexes were normal, no atrophy was found, no evidence of nerve deenervation was observed. Dr. Ha'Eri would expect to find nerve deenervation where severe pain due to an orthopedic injury has been present, as the severe pain from the orthopedic injury will cause dis-use of that body part, resulting in atrophy from nerve deenervation. Applicant's neurological, sensory and motor examination showed no significant impairment as a result of any orthopedic injury or condition.

50. Dr. Ha'Eri had the opportunity to observe several x-ray reports and MRI studies found in the Kaiser Permanente records. He noted that the MRIs all showed mild degenerative disc disease at four levels of six in applicant's cervical spine, and one level of degeneration at L5-S1 in applicant's lumbar spine. Dr. Ha'Eri described what was shown in the MRIs as normal age-related degenerative disc disease, age-appropriate, much like, as he described it, "the gray hairs of the spine." Dr. Ha'Eri noted that L5-S1 carries a substantial portion of a person's body weight, and yet she showed only mild facet joint degeneration, and less arthritis than in her cervical spine, yet applicant's cervical spine was asymptomatic. He observed that applicant did sedentary work, was not overweight, and had experienced no accident or trauma to her low back since she was younger and fell off the horse many years ago.

51. Dr. Ha'Eri reiterated his opinion that applicant had no orthopedic disability in his testimony. On cross-examination, he acknowledged that he did not perform any psychological or psychiatric examination, nor any pulmonary examination, and that his charge was to perform only an evaluation of applicant's orthopedic condition. He acknowledged that his opinion that applicant had no orthopedic disability did not exclude that there can be other reasons for back pain besides orthopedic injury or disability, including depression, gynecological problems, fatigue, anxiety, lack of fitness, psychological factors, and psychosomatic factors, all of which are beyond the scope of an orthopedic evaluation. Dr. Ha'Eri also acknowledged that despite the fact that he was asked to review a considerable portfolio of medical reports and records, he saw no psychiatric evaluation, psychological evaluation, or any records of pulmonary evaluation including any analysis of the effects of applicant's COPD.

DR. HASLEWOOD'S IME

52. Douglas Haslewood, M.D., F.A.C.R., is a Board-certified Rheumatologist. Dr. Haslewood performed a rheumatological IME on applicant on June 23, 2014, to assess her for rheumatologic and musculoskeletal afflictions relative to her claim of long-term physical vocational disability. Dr. Haslewood reviewed applicant's duty statement with her in order to make sure he had an accurate understanding of the demands of her work. Applicant told him that her job was primarily that of a secretary in a correctional facility Emergency Department, and that the job description provided by CDCR was accurate. She agreed with Dr. Haslewood's characterization of her work requirements as sedentary clerical/administrative work.

53. Applicant told Dr. Haslewood that she began to experience an increasingly more persistent and bothersome widespread musculoskeletal pain when she was in her 40s. She described her perception of her increasing pain as “a relentless progression” of low back, and then later widespread pain/spasms, especially in conjunction with her COPD and PTSD. Applicant reported that she found it increasingly more difficult to maintain the physical demands of keeping up at work. Applicant told Dr. Haslewood that by Spring 2012 she was “in agony” due to her widespread musculoskeletal pain, to the point that she “could not function,” and therefore opted to stop work in June 2012.

54. Dr. Haslewood wrote in his IME report that at the time applicant stopped working, the pathophysiologic origins of applicant’s widespread musculoskeletal pain were evidently unexplained and unknown. Applicant was tested for Valley Fever, with the thought that perhaps that was causing her musculoskeletal pain symptoms, without success. Applicant told Dr. Haslewood that in August 2012 she went through a “rheumatologic consultation” at the end of which she was told she had “fibromyalgia.” She received a referral back to her pain management program without further rheumatological assessment or treatment. The motor vehicle accident in the summer of 2012 compounded applicant’s problems significantly. Applicant’s reaction to the accident included panic attacks and various driving-related phobias. Applicant was diagnosed with PTSD after the auto accident and has remained under psychiatric/psychological counseling surveillance since.

55. Applicant told Dr. Haslewood that, at the time of his June 23, 2014, examination, applicant’s chronic moderate-to-severe widespread soft-tissue and articular tenderness and spasms were her worst symptoms, followed in order by chronic moderate-to-severe low back pain, and then chronic mild to moderate right hand pain, spasm and dysfunction. Applicant also told Dr. Haslewood that she has constant difficulty with poor sleep and ongoing psychological issues related to her PTSD. Applicant also complained of a chronic cough and of shortness of breath on exertion, due to her COPD.

56. Applicant told Dr. Haslewood that lack of employment and financial and insurance constraints have severely limited her ability to obtain medical treatment. She presently only sees her primary care physician for medications, and has a monthly session with a psychiatrist and/or counselor. Dr. Haslewood noted in his IME report that as of the time of his examination applicant was using a 25 mg fentanyl patch as often as twice per day on a patient determined need basis, Percocet, five mg. tablets, one to five tablets per day as per patient determined need, and additionally Soma, Valium, a statin drug, an antihypertensive, and uses an inhaler.

57. Dr. Haslewood performed a clinical joint and musculoskeletal examination of applicant that was limited by applicant’s request that he not examine her neck or low back, with the exception of using very minor light touch. Applicant told him that she had tenderness all over her sacral and lumbosacral regions, and exhibited limitations in motion of approximately 50 per cent in each direction. Applicant also told him she had tenderness all over her posterior neck, and exhibited regarding limitations in motion by approximately 25 per cent in all directions. Applicant had a well-healed scar over the base of her right thumb

where she had surgery, and mild tenderness at the bony prominence. Dr. Haslewood observed minor age-appropriate osteoarthritic changes in her distal finger and toe joints, with the remainder of his joint examination benign, without consistent tenderness or evidence of either chronic or active synovitis.

58. Dr. Haslewood conducted only a light touch soft-tissue musculoskeletal examination, and as he did so, applicant told him of discomfort, and exhibited withdrawal and guarding mechanisms. Dr. Haslewood noted in his IME report that applicant's expressions of discomfort, and mechanisms of guarding and withdrawal, were inconsistent and non-physiologic, meaning they were exaggerated, implicating significant "non-organic symptom embellishment." Dr. Haslewood also noted that when applicant walked while in the exam room, she was quite slow and unsteady, but when he later watched her walking into and leaving the exam room, and the building, her gait was more fluid and rapidly paced.¹ Like Dr. Ha'Eri, Dr. Haslewood found no sensory, reflexes or motor defects noted on neurological examination, and negative straight leg raising symptoms from the sitting position.

59. Dr. Haslewood diagnosed that applicant had chronic, complex, widespread musculoskeletal pain and dysfunction syndrome, presumptively representing the cumulative effect of: A. Age-appropriate appendicular osteoarthritis and posttraumatic right thumb arthropathy; B. Age-appropriate cervical and lumbosacral vertebral degenerative phenomenon; C. Nonspecific widespread myofascial discomfort with hypervigilance for same, historically characterized as the syndrome of fibromyalgia; and a significant element of "non-organic amplification presumably related to psychosocial issues, PTSD, etc." Dr. Haslewood also diagnosed that applicant had comorbid issues such as COPD.

60. Dr. Haslewood concluded and opined that applicant does have, "some legitimate (albeit predominantly age-appropriate) sources of musculoskeletal discomfort and dysfunction." He also stated:

The unusually high, diverse and incapacitating level of widespread musculoskeletal pain and dysfunction and the resulting levels of physical impairments perceived by applicant are based, to a large part, on self-reporting and subjective criteria.

61. Dr. Haslewood pointed out that the most recently published guidelines by the American College of Rheumatology (ACR) permits the diagnosis of the syndrome of

¹ The ALJ made similar observations before, during and after the evidentiary hearing. Whether a function of "symptom embellishment" or simply a function of psychosomaticization, "Mind-Body" syndrome, or something similar of psychogenic origin, applicant presented to both IME physicians as psychologically convinced that she hurts and is more disabled than can be associated with any organic functional or physical condition, injury or illness.

fibromyalgia based entirely upon patient self-reporting, without the necessity for any correlating clinical or physical abnormalities. Dr. Haslewood stated that he could not technically discount that previous healthcare providers such as Dr. Fung, a rheumatologist, felt that applicant's presentation was consistent with the syndrome of fibromyalgia. However, he stated, based upon the entirety of the medical records and current examination findings, that:

I cannot confirm the diagnosis of the syndrome of fibromyalgia with the presumption that such a diagnosis could, in any reasonable fashion, provide objective criteria upon which to determine parameters of permanent and profound physical impairment. Although put forward initially as a mechanism for providing 'objective' criteria for the diagnosis and severity of the syndrome of fibromyalgia, it became apparent in interval years that tender points were notoriously subjective and manipulative. Thus, the ACR is in the process of eliminating tender points for diagnosing, and determining the severity of fibromyalgia is based on self-reporting only.

There is, obviously, no evidence-based objective mechanism for determining the actual severity of fibromyalgia in any given individual. Pending much more convincing evidence to the contrary, it appears that applicant's healthcare providers are using the syndrome of fibromyalgia as a convenient 'default diagnosis' to characterize more complex physical and mental health problems, most of which do not correlate with unusually severe musculoskeletal pathophysiology. ...

Unfortunately, the healthcare providers provide no objectively based algorithm by which they determined that the syndrome of fibromyalgia or explanation of how it would be expected to permanently preclude applicant from sedentary physical vocational functionality. With the PTSD and other implied psychosocial issues, it is possible that applicant may not have the psychologic stamina to deal with the rigors of full-time employment even under the most sedentary and accommodating of settings, but this would have to be deferred to more appropriate psychiatric opinion.

Based solely upon the currently available medical record, historical and physical evidence relative to the rheumatologic aspects of this case, applicant currently possesses the physical capabilities of participating in full-time sedentary work with a reasonable expectation of continuity.

62. Dr. Haslewood opined that with regard to applicant's physical capabilities, there are no specific job duties she is unable to perform. He observed during her examination that applicant was cooperative, but, "put forth sub-optimal physical effort during the physical examination." He noted that in the context of his musculoskeletal/soft-tissue portion of the examination, applicant's discomfort, guarding and withdrawal mechanisms, "were inconsistent and non-physiologic, implicating significant nonorganic symptom amplification."

DR. HASLEWOOD'S SUPPLEMENTAL IME REPORTS

63. Dr. Haslewood wrote two Supplemental IME reports, the first dated June 15, 2015, and the second, November 25, 2015. Both Supplemental IME reports were generated in response to requests by CalPERS BSD to review medical records and diagnostic imaging studies provided by applicant in support of her claims. Dr. Haslewood found nothing in the additional medical reports and diagnostic studies that would cause him to change his opinions expressed above, and so noted those opinions in his first and second supplemental IME reports.

64. Dr. Haslewood's Second Supplemental IME report reviewed records from Camarena Health Primary Care Clinic, where Dr. Nomicos and Dr. Bernstein treated applicant from November 2013 through June 2015. Dr. Haslewood pointed out that in the office visit records for April 13, 2015, some tests were conducted that suggested the possibility that applicant may have shown signs of rheumatoid arthritis. Applicant was treated for rheumatoid arthritis at Camarena by her physicians. She was prescribed various medications for several conditions including chronic strained lumbosacral ligament, lumbar disc degeneration, lumbar radiculopathy, sciatica and musculoskeletal tenderness. Dr. Haslewood noted that there was no clinical assessment in any of the Camarena records to support a diagnosis of rheumatoid arthritis.

65. Dr. Haslewood pointed out that the medical records from March-April 2015 showed some, "rather surprising and somewhat paradoxical evidence which is difficult to interpret absent a more contemporary rheumatology evaluation." He pointed out that applicant's laboratory studies performed during this period of time were abnormal, showing a significantly positive rheumatoid factor and anti-CCP antibodies, which, until proven otherwise, "would be considered to be highly suspicious of occult or evolving rheumatoid arthritis." He also commented, "Unfortunately, the current corresponding abundant primary care medical records reviewed above, rather surprisingly, do not describe consistent and unequivocal historical features or musculoskeletal abnormalities consistent with an occult or evolving rheumatoid arthritis." Dr. Haslewood referred to a Rheumatologic Evaluation of August 22, 2012, performed by Dr. Fung, which noted variable elevated sedimentation rates and an apparent elevated rheumatoid factor, but also noted that Dr. Fung's evaluation, "documented no evidence of an occult or evolving synovitis, and did not entertain rheumatoid arthritis as a diagnosis." He noted that his own examination of applicant, on June 23, 2014 (the IME), did not document musculoskeletal abnormalities consistent with an active or emerging rheumatoid arthritis.

66. Dr. Haslewood concluded that the additional medical records do not document unequivocal and consistent evidence of progressive musculoskeletal pathophysiology and associated impairments. He found nothing in these records that would cause him to change his opinions, findings and conclusions regarding applicant's vocational physical functionality, as reported in his initial IME.

67. Dr. Haslewood did, however, recommend that, in the context of applicant's ongoing comprehensive care, that she undergo an updated and thorough rheumatological evaluation to see if there is indeed current evidence of an emerging rheumatoid arthritis that might be overshadowed by her chronic, degenerative mechanical and musculoskeletal problems with a presumption of fibromyalgia. He confirmed that, based on the information provided to him at the time of his Second Supplemental IME report, in September 2015, there was insufficient documented medical evidence of musculoskeletal abnormalities that would be expected to permanently preclude applicant from performing her job duties at her sedentary occupation.

DR. HASLEWOOD'S TESTIMONY

68. Dr. Haslewood's testimony closely mirrored his opinions expressed in his IME report, and particularly as updated in his September 2015 Second Supplemental IME report. He reiterated that applicant has not worked since June 29, 2012, yet her condition has not improved, and reminded that he evaluated her for her functionality based on a sedentary clerical and administrative position doing support work for a medical staff.

69. Dr. Haslewood explained his observations and activities during the clinical physical examination he performed on applicant as part of his IME, and particularly his observations of her behavior and presentation. He noted applicant presented herself with a depressed affect, with frequent coughing upon deep breaths, and that she asked him repeatedly not to touch her except with a very light touch. He pointed out what he wrote in his report about applicant's inconsistent guarding behavior, pain reports and reactions to his light touching led him to conclude that applicant's presentation, guarding and complaints of pain upon touching were all factors reflecting a "non-organic embellishment." He also reminded that he watched applicant walk in and out of the clinic with a gait much more fluid and normal than when she was in his immediate presence in the examination room being directly assessed.

70. Dr. Haslewood testified that applicant has, "lots of complaints that cannot be explained." Her "nonspecific" complaints of pain are widespread, and his conclusion is that these complaints of pain are presumptively related to psychologic conditions. He testified that, "you cannot really disapprove fibromyalgia under current criteria, because it is now based entirely upon self-reporting, and there is no physiologic pathway to confirm or rule it out." "It is a syndrome, a basket of self-reported symptoms." Dr. Haslewood pointed out that under current standards, persons who report nonspecific symptoms of pain and dysfunction can be found to have fibromyalgia without any objective confirming evidence discovered in the clinic.

71. Dr. Haslewood made a point of warning, in the context of these proceedings, that the diagnostic criteria from the ACR for describing fibromyalgia were, "never meant to be criteria for determining vocational functionality." He continued, "Fibromyalgia is a convenient default diagnosis to dump complex physiological and mental health problems."

72. Dr. Haslewood confirmed that it is still his opinion that applicant's constellation of conditions and complaints do not prevent her from being able to perform sedentary clerical and administrative job duties, and that there are no duties on her job duty statement that she cannot perform. When challenged on cross-examination, he confirmed that he is, "not skeptical of fibromyalgia," that it is an entity, and yes, he has diagnosed it, but expressed the reservation that it is, "a very subjective, entirely-patient determined condition," and those factors make it "almost impossible to assess vocational functionality and disability."

73. Dr. Haslewood deferred any comment on whether applicant actually has a medically sustainable diagnosis of PTSD. He accepted that it is possible that if she does have PTSD, she might not be able to cope with the psychological problems inherent to working in an institution. He discussed the "surprising and paradoxical evidence" of the primary care blood testing that might show the possibility of rheumatoid arthritis, but went no further than to confirm his opinion that a full rheumatoid arthritis workup should be performed. He pointed out applicant needs a thorough physical examination and history, followed by additional blood testing and a full scale rheumatoid arthritis workup, using the earlier tests as a baseline, and that this has not been done.

74. Dr. Haslewood deferred on applicant's other comorbidities such as her psychosocial issues, PTSD, and COPD. He noted he did not perform a psychological evaluation, nor will he express a psychological opinion. He noted that there are no records of a pulmonary examination, and that applicant's COPD diagnosis is historical only in that it is noted in the earlier records. He confirmed "applicant has conditions going beyond rheumatologic evaluation." But he also pointed out that "a vast majority" of rheumatological patients can function fairly well in the workplace, especially with sedentary activities.

APPLICANT'S CREDIBILITY

75. Applicant's credibility reporting her symptoms, limitations and disabilities was poor. Applicant presented herself as being all but completely dominated by her pain, how her pain makes her feel and her pain's limits on what she can and cannot do. She made it apparent that her pain fully dominates her thinking and her life. She was slightly weepy, quietly overstated and a bit theatrical in how she described herself, her conditions and her limitations in her testimony. Applicant has consistently claimed over decades now that she experiences genuine sensations of pain, the severity and scope of which has been increasing over time, all over her body, but particularly in her low back, and the medical records show how her increasingly self-consuming response to those perceptions. Those responses, however, are somewhat inconsistent, as persuasively documented and pointed out by Dr.

Haslewood, and consistently failed to line up with the objective medical evidence obtained through numerous medical visits, testing, and repeated diagnostic imaging.

76. Regardless, applicant is fully convinced that she is wholly and completely disabled, housebound and unable to care for herself or work, and that her condition will stay at least as bad as it is or get worse for the rest of her life. There appears to be no amount of objective medical evidence and diagnostic testing results that can persuade her otherwise.

77. Applicant's claims of disability and limitation, inability to work, inability to care for herself, inability to cope with any requirements of daily living or self-care outside of her front door is a moving and changing target, and wholly and entirely based upon applicant's self-report. Applicant's self-reported claims of her various conditions and resultant disabilities and limitations is her entire case, as there is no medical evidence in this record that does anything other than echo and responds to her self-reported complaints. One of many examples of this is found in the Kaiser and Camarena Health records where applicant complained of pain from her low back radiating down her legs, then a diagnosis of sciatica appears, yet both IMEs found that applicant's straight leg raising with both legs produced almost no pain or limitation of motion, test results indicative of no sciatic nerve involvement. None of applicant's medical records have any clinical analysis, testing, or other objective orthopedic or rheumatological findings that connect the dots between applicant's claims of pain and confirmation of an underlying medically recognized orthopedic or rheumatological condition that can produce the symptoms she reports. In fact, the medical evidence often contradicts or juxtaposes what conditions are identifiable and what applicant reports, such as applicant's reports of intense lower back pain, where diagnostic imaging shows only mild, normal age-related degenerative changes, and yet she does not complain of cervical spinal pain, where the diagnostic images shows a more advanced stage of degenerative changes that might likely produce more pain than her low back condition.

78. A historical overview of applicant's medical history and claims history appear to show a pattern of strong motivation to seek out and obtain medical opinion to find her disabled. Applicant's report of claimed disabling conditions, highlighted by her presentation in the evidentiary hearing, has a smorgasbord feel, where lack of success in obtaining medical confirmation of disability on any given condition elicits redoubled efforts to present new or additional conditions to shore up the claim. The history of applicant's claims present a rather fluid and moving progression of increasing severity over time, along with an equally apparent pattern of movement away from objectively verifiable conditions to claims that are completely unverifiable beyond applicant's self-reports. What is truly striking is that applicant can function at all, considering the number and types of opiate based pain medications and dependency causing anxiolytics she is taking together, sadly without much apparent effect in either reducing her complaints of pain or her reports of anxiety.

79. Applicant's credibility is essential to her case, and, as a corollary matter, her lack of credibility, in this instance, is fatal to her claims here. The lack of credibility of

applicant's self-reports was a key factor underlying the IME medical opinions finding applicant not disabled.

ANALYSIS OF THE RELATIVE PERSUASIVENESS OF THE MEDICAL EVIDENCE AND EVIDENCE OF INCAPACITY

ORTHOPEDIC

80. There is no credible and persuasive medical evidence in this record of applicant's claim of an orthopedic disability to her cervical and lower spine besides Dr. Ha'Eri's IME evaluation. Dr. Ha'Eri's IME evaluation is uncontroverted in any material respect. Applicant's orthopedic medical evidence contains several diagnostic testing images on MRIs that consistently show no more than ordinary degenerative age-related degeneration in her spine, entirely normal findings considering her age, body mass, activity level, and work activities. Applicant's degenerative osteoarthritic changes were shown on MRI studies repeatedly to be worse in her cervical spine, where she does not complain of symptoms, than in her lumbosacral spine, where she complains of all but crippling incapacity due to pain. Applicant does not suffer from any disability or incapacity stemming from any recognized orthopedic condition, injury, illness or abnormality.

RHEUMATOLOGIC

81. Applicant has been diagnosed with a plethora of myofascial pain syndrome-type conditions, including fibromyalgia. As Dr. Haslewood persuasively pointed out in detail, these diagnoses are entirely the product of applicant's self-report. There was no persuasive medical evidence in the record to refute Dr. Haslewood's well-reasoned, carefully thought out and explained and therefore persuasive and credible opinion that there is no reason why applicant is unable to work at a sedentary clerical job with the conditions that he observed during his IME rheumatologic clinical examination. There is no information in all of applicant's medical records that contain any medical findings or conclusions based upon evaluations that reasonably support a contrary conclusion.

82. All of applicant's medical opinions in support of her claims are the product of medical treater acceptance of applicant's self-reports. Applicant's medical opinions in support of her claims, evaluated closely, as did Dr. Haslewood, contain little more than an analysis-free series of physician endorsements of applicant's reports of pain, and efforts to respond to her desire to be found disabled. Most important here, and as sharply pointed out by Dr. Haslewood, none of the reports and opinions from applicant's physicians contain any vocational analysis, correlating their opinions regarding applicant's conditions to her job requirements and explaining why they believe applicant's medical condition prevents applicant from being able to perform any or all of her sedentary clerical duties. These opinions are consistent in one respect; they all conclude applicant is disabled without explaining what it is she is disabled from, what it is she can and cannot do with respect to any specific condition, and why they believe so. None of these opinions explain why applicant is unable, as a result of any or all of the conditions she reported and they

diagnosed, to perform her usual and customary duties in a sedentary position as a clerical person at CCWF.

APPLICANT'S OTHER CLAIMS OF DISABILITY AND THEIR CONTRIBUTORY EFFECT

83. Applicant contended at the evidentiary hearing that she suffers from at least three other disabling conditions that are contributory factors to her disability and incapacity, and that these additional disabling conditions "should have been evaluated by CalPERS." Applicant so contends because applicant claims there is evidence in her medical records that she suffers from these conditions, and that applicant could not be expected to know of all of her disabling conditions and illnesses and identify them at the time she filled out the application. Applicant's claims in this respect were striking in that applicant by so claiming sought to shift responsibility to CalPERS for applicant's failure to produce persuasive medical evidence in support of her claims, and to shift to CalPERS applicant's responsibility to make a reasonably accurate claim regarding the factors she claims lead to her disabilities. In so claiming, applicant disavowed any responsibility for the accuracy of her application, and contended that it was CalPERS's responsibility to make sure that everything that could possibly be disabling applicant was identified and evaluated.

84. Applicant contends that CalPERS should have seen and had her evaluated for the effects of her COPD, her PTSD and other psychiatric factors, and her emerging rheumatoid arthritis condition. There is evidence in the record that applicant has been diagnosed or at least it has been suggested that applicant suffers from COPD. The same records reveal that applicant is a long-term smoker, and continues to smoke at least a half pack of cigarettes per day. Both IME physicians for CalPERS deferred with respect to applicant's COPD, as both claim no expertise in pulmonary medicine. Applicant did not claim disability on the basis of COPD in her application, nor did she ask to be evaluated by any of her physicians for disability or contribution to her disability based on COPD.

85. The same result was had when both IME physicians were asked about applicant's claim to PTSD, and/or other psychiatric factors. There is some suggestion in applicant's application that PTSD could be a disabling factor, but it was undisputed that the claimed triggering event for applicant's PTSD was a July 2012 auto accident that occurred well after applicant's last day of work for CDCR CCWF. Thus, the claimed PTSD, if it exists, could not have been an industrial cause of applicant's claimed disability.

86. Applicant's psychiatric claim was not made in her application, and was not raised until late in the evidentiary hearing, when applicant's counsel asked both IME physicians for their opinions about applicant's psychiatric condition as that relates to applicant's claims of whole body, nonspecific, intense but variable pain that follows no known neural pathways. Counsel sought both IME physician's opinions regarding whether applicant's pain reports, and the diagnoses of myofascial pain, musculoskeletal pain and fibromyalgia, are not actually the product of a disabling psychiatric condition; a disabling psychosomatic condition. Both physicians again deferred, pointing out that psychiatry is not

their specialty. There is no psychiatric evaluation or assessment in this record, and CalPERS was not on notice that applicant's psychiatric condition was a claimed disabling condition, either on its own or in conjunction with applicant's other claims, until late in the evidentiary hearing.

87. The indication for applicant's potential to have an occult or a late developing rheumatoid arthritis condition was not discovered until more than two years after her last day of work. There is no evidence that applicant ever suffered from rheumatoid arthritis at any time while she was employed with CDCR CCWF. Applicant's potential for rheumatoid arthritis is far from a solid and well supported medical diagnosis, as Dr. Haslewood pointed out, a confirmatory full-scale rheumatological workup needs to be performed, using the 2014 test results as a baseline to determine whether applicant has an occult or developing rheumatoid arthritis. Dr. Haslewood was quite skeptical that further testing and evaluation will support the diagnosis, except as to the potentiality of the condition developing going forward in time. He made it clear he looked carefully and found no documentation in any of applicant's medical records of any synovitis that would indicate that the rheumatoid arthritis had ever been symptomatic during the period of time applicant was employed by CDCR CCWF. There is no evidence in any of the records that applicant experienced any limitation, disability or incapacity as a result of rheumatoid arthritis during the period of time she worked for CDCR CCWF.

88. Applicant's medical evidence does not support any claim of disability or incapacity suffered by applicant as arising out of or caused by her work at CDCR, CCWF, regardless of the claimed cause or combination of causes in her application, and even considering COPD, PTSD, psychiatric condition, and/or rheumatoid arthritis. Applicant's medical evidence is wholly unpersuasive, lacks medical analysis and supportive objective medical findings and test results, but even more so because it is almost entirely founded upon applicant's credibility, which, as set forth above, was poor.

LEGAL CONCLUSIONS

BURDEN OF PROOF AND PRODUCTION OF EVIDENCE

1. "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."² 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.³ An applicant for a CalPERS disability retirement bears the burden of proof and the

² *McCoy v. Board of Retirement of the County of Los Angeles Employees' Retirement Association* (1986) 183 Cal.App. 3d 1044, 1051.

³ *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.

burden of going forward with the evidence.⁴ *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.⁵ 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.⁶ Evidence that is deemed to preponderate must amount to “substantial evidence.”⁷ Evidence must be reasonable in nature, credible, and of solid value in order to be “substantial.”⁸

2. “‘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.”⁹

3. “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....”¹⁰

4. “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.”¹¹ *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.

5. 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 substantial incapacity for the purposes of a disability retirement.¹² The fact that the physical or psychological condition may preclude the applicant from performing some but not all

⁴ *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.

⁵ *Mansperger*, *supra*.

⁶ Evidence Code section 115.

⁷ *Weiser v. Board of Retirement* (1984) 152 Cal.App.3d 775, 783.

⁸ *In re Teed’s Estate* (1952) 112 Cal.App.2d 638, 644.

⁹ Government Code section 20026, in pertinent part.

¹⁰ Government Code section 21156, in pertinent part.

¹¹ *Mansperger v. Public Employees’ Retirement System* (1970) 6 Cal.App. 3d 873, 876.

¹² *Hosford v. Board of Administration* (1978) 77 Cal.App. 3d 854, 861-863.

usual and customary job duties does not necessarily mean the applicant is substantially incapacitated within the meaning of *Mansperger* and section 21156.¹³

SUBSTANTIAL INCAPACITY AND FUNCTIONALITY-CONCLUSION

6. The determination of whether an IDR applicant is “substantially incapacitated” pursuant to the *Mansperger* and *Hosford* standards requires a functionality evaluation; i.e., does the nature and level of the disabling disease, condition or injury, when weighed against the applicant’s usual and customary duties as actually performed in the workplace, disclose a substantial impairment of the applicant’s ability to perform, and does it appear to a reasonable medical certainty that that impairment will last indefinitely. Applicant’s medical evidence, as set forth in the Factual Findings, contains no persuasive functionality analysis and evaluation. Applicant failed to meet her burden of proof to tie with persuasive medical evidence any or all of her claimed disabling conditions, those noted in her application, and even those she attempted to add during the course of the evidentiary hearing, to persuasive opinion of functional incapacity and limitation sufficient to meet the *Mansperger* and *Hosford* standards.

7. It is not CalPERS’ responsibility to analyze and identify all potential causes for disability when an applicant seeks the benefit. The applicant must bear primary responsibility for identifying his or her claimed disabling conditions, and cannot be heard to complain later that the claim should be granted because CalPERS “missed” a potential disabling condition not identified by the applicant, but perhaps buried in a mass of medical records. CalPERS’ responsibility to evaluate a claim for disability retirement is limited to the disabling conditions applicant claims in the application, and any additional factors that might be added upon specific identification by an applicant and/or her counsel called to CalPERS’s attention in a timely fashion and supported by medical evidence. Doing so late in the evidentiary hearing and in closing argument is, at the least, untimely, and CalPERS is under no obligation to revisit the application and to continue to arrange for additional IMEs to evaluate last-minute claims of conditions not disclosed until almost the moment the record closed.

8. The claim here that CalPERS should have identified applicant is potentially disabled by COPD, PTSD, psychiatric condition, and/or rheumatoid arthritis, is disingenuous, in that the claim suggests that CalPERS should have identified these conditions because the record suggest them and then done the work up through IME evaluations to prove applicant’s claim has merit. The contention upends and reverses the statutory requirements that an applicant claiming disability retirement identify the claimed disabling condition, produce medical evidence supporting the claim, and if disputed by CalPERS, then an IME is ordered to assess whether applicant’s medical evidence does or does not have merit. The system does not place an obligation on CalPERS to order an IME in order to prove what applicant is required to prove as a threshold matter, or to develop

¹³ *Id.*

medical evidence in support of an applicant's claim, rather than assessing and evaluating medical evidence already produced by applicant in support of the claim.

ORDER

The appeal of Wendy Macy a.k.a Lucas of the CalPERS BSD's denial of her application for an industrial disability retirement is **AFFIRMED**. The application of Wendy Macy, a.k.a. Lucas for Industrial Disability Retirement is **DENIED**.

DATED: June 8, 2016

DocuSigned by:

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STEPHEN J. SMITH
Administrative Law Judge
Office of Administrative Hearings