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: ANDREW J. BOROVANSKY, Respondent, and CITY OF SACRAMENTO, Respondent.	Case No. 2016-0198 OAH No. 2016040101

PROPOSED DECISION

This matter was heard before Karen J. Brandt, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, on June 30, 2016, in Sacramento, California.

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

Andrew J. Borovansky (respondent) represented himself.

There was no appearance by or on behalf of the City of Sacramento (City).

Evidence was received on June 30, 2016. The record was left open to allow respondent to submit a closing brief. On July 14, 2016, respondent submitted a closing brief, which was marked for identification as Exhibit H. The record was closed and the matter was submitted for decision on July 14, 2016.

ISSUE

On the basis of an orthopedic (neck, back, left shoulder) condition, is respondent permanently disabled or substantially incapacitated from performing his usual and customary duties as a Construction Inspector II for the City?

FACTUAL FINDINGS

1. Respondent was employed as a Construction Inspector II by the City. On June 12, 2014, CalPERS received respondent's Disability Retirement Election Application (application), seeking service retirement pending industrial disability retirement. Respondent retired for service effective July 10, 2014, and has been receiving his service retirement allowance from that date.

Respondent's Application

2. In his application, respondent described his disabilities as: "Spine injury (L-1 fracture), neck injury, shoulder injury, brain injury." He stated that his injuries occurred on July 11, 2012, when he "fell down [a] stairway." He described his limitations/preclusions as follows:

> QME has my back [and] shoulder permanent [and] stationary.[1]

In his application respondent stated that he was still working full time, and that he was "using [his] vacation until app on 07/07/2014."

3. By letter dated November 13, 2015, CalPERS notified respondent that it had denied his application. In the letter, CalPERS stated that its "review included the reports prepared by Stephen P. Abelow, M.D., Carl Shin, M.D., Scott Lipson, M.D., and Robert Henrichsen, M.D.," and that based on "the evidence in those reports, [CalPERS had] determined your orthopedic (neck, back, left shoulder) conditions are not disabling." The letter also stated that, "Since medical evidence submitted by you does not support a disabling brain condition, your allegation of disability due to an injury to your brain was not considered in our evaluation of your industrial disability retirement application." The November 13, 2015 letter notified respondent that he had 30 days to file a written appeal from the denial.

4. By letter dated January 14, 2016, respondent appealed from CalPERS' denial of his application. In his appeal letter, respondent stated that he had been employed by the City from 1981 to July 2014. On July 11, 2012, he fell down a staircase. The City "removed [him] from employment in July 2014 stating that [his] injury prevented [him] from doing [his] job adequately." At the hearing, CalPERS confirmed that it was not contesting the timeliness of respondent's appeal, and respondent confirmed that he was not seeking disability retirement based upon a brain injury.

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[1] "QME" stands for a qualified medical evaluator in a workers' compensation case.

Duties of a Construction Inspector II

5. CalPERS submitted two exhibits that described the duties of a Construction Inspector II: (1) the City's Specification Bulletin; and (2) an "Essential Job Functions Analysis."

6. As set forth in the Specification Bulletin, a Construction Inspector II "inspects workmanship and materials used in the construction work of a variety of public and private projects to insure conformance with applicable laws, ordinances, standards, plans, specifications, and departmental regulations." A Construction Inspector II "works under general supervision and is expected to perform the entire range of field inspection work requiring a complete knowledge of construction inspection principles and practices."

7. The Essential Job Functions Analysis stated that a Construction Inspector II: (1) rarely (less than 10 minutes a day) power grasps, lifts more than 20 pounds, carries more than 10 pounds, climbs steps, kneels (maximum one hour not every day); (2) occasionally (10 minutes to three hours a day) engages in repetitive hand motions, simple grasping and finger dexterity, stands, walks, lifts up to 20 pounds, carries up to 10 pounds, squats, reaches above the shoulder, pushes and pulls, bends and twists at the neck and waist, and balances; and (3) frequently (three to seven hours a day) moves his hands, sits, and reaches below the shoulder.[2]

Expert Opinion

8. CalPERS retained Robert Henrichsen, M.D., to conduct an Independent Medical Evaluation (IME) of respondent. Dr. Henrichsen is board-certified as an orthopedic surgeon. Dr. Henrichsen examined respondent on October 20, 2015, took respondent's medical history, reviewed respondent's medical records, and prepared an IME report.

9. At the time of the IME, respondent was 57 years old. Respondent told Dr. Henrichsen that he fell down stairs on July 11, 2012, and that he suffered injuries to his left biceps and left shoulder, had some neck pain, and had a concussion. After his fall, respondent was hospitalized for a few days, and used a thoracolumbar orthosis for six or seven months.[3] When respondent returned to work, he worked light duty for six or seven months. Respondent had two left shoulder surgeries, the first on July 23, 2013, and the second on October 13, 2014. Respondent fractured his back in a motorcycle accident in approximately 1990. There was a question of whether his back was broken again by his fall down the stairs. Dr. Henrichsen believed that a new fracture of the back was not identified in 2012. Dr. Henrichsen noted that headaches were respondent's "biggest problem" after his

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[2] Respondent submitted a completed Physical Requirements of Position/Occupational Title, which was fairly consistent with the Essential Job Functions Analysis.

[3] A thoracolumbar orthosis is a "medical device that is worn on the trunk and whose purpose is to support the lumbar spine." It can be used in cases of "fractures of the lumbar vertebrae." (http://health.ccm.net/faq/4043-orthopedic-lumbar-corset-definition.)

fall. He had chiropractic treatments. As a result of these treatments, his headaches initially went away, but gradually returned. He generally had headaches at night.

10. Respondent complained of numbness in his right forearm from a previous injury, headaches, stiffness in his neck, low back pain, pain in his left shoulder with motion, and a feeling of weakness in his shoulders. He also stated that his low back "seems to give way."

11. Dr. Henrichsen's examination was restricted to respondent's spine and extremities. After examining respondent and reviewing his medical records, Dr. Henrichsen diagnosed respondent as follows:

1. Degenerative arthritis of the cervical spine with a history of cervical sprain.
2. History of L1 fracture in 1980 [*sic*] healed.
3. Lumbar sprain with degenerative arthritis of the lumbar spine and degenerative disc disease.
4. Left shoulder injury with rotator cuff tear and biceps tenotomy, now resolved.
5. Capsular fibrosis, left shoulder, with changing range of motion of the left shoulder.
6. Nocturnal occipital headaches.
7. Previous laceration of left wrist with permanent median nerve dysfunction.
8. Unfavorable power-to-weight ratio.
9. History of resolved depression.

12. Dr. Henrichsen, in his IME report, discussed lifting restrictions that Dr. Shin and Dr. Abelow had placed on respondent. Dr. Henrichsen stated that these restrictions were "prophylactic" and that he could not understand from the records why these prophylactic restrictions were imposed. According to Dr. Henrichsen, "there is no nerve impingement from the neck or the low back." Dr. Henrichsen stated:

> As I look at the orthopedic and spine issue, I can identify that his cervical spine does not limit him from his occupational work nor does his left shoulder. He has reasonable mobility of both his neck and his low back. While I recognize he has some reduced motion in his left shoulder and he has some pain, when one looks at the overall integrity of the records, the left shoulder has done well following that second surgery with good pain relief and good motion. That leaves the headache issues and the headache issues are best determined by Dr. Reimer or Dr. Shin.
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> His left hand does not limit him because that injury to his left wrist was about 1980 and he has accomplished his work for a long time interval since.

13. Dr. Henrichsen opined that respondent was not substantially incapacitated for the performance of his duties as a Construction Inspector II. Dr. Henrichsen found that there were no specific job duties that respondent could not perform. Dr. Henrichsen did, however, state that he was not presented with any x-rays to review, and that if he were presented with new x-rays of respondent's neck and low back, that information "may or may not change my opinion regarding his work capacity."

14. At the hearing, Dr. Henrichsen described his examination of respondent. He found that respondent's neck motion was a "little diminished," but it was good overall. Respondent had some reduced mobility in his left shoulder. He also had some difficulty with his left hand, due to an old injury, that resulted in some loss of function. Dr. Henrichsen explained that, although he did not receive any actual x-ray films to review himself, he received reports which included interpretations by doctors of x-rays that had been taken, which Dr. Henrichsen reviewed.

Respondent's Testimony

15. At the hearing, respondent testified about his work and injury history. On July 11, 2012, he fell 25 feet to a concrete floor. He testified that he suffered a traumatic brain injury, fractured his lumbar spine, and injured his neck, shoulder and ribs. He was in the ICU for three days. After he was discharged, he had to wear a back brace. He had shoulder surgery in 2013, which initially "seemed to take," but thereafter he tore his biceps from the bone. He received physical therapy for his back and shoulder, and then had another surgery on his shoulder. He also received cortisone shots.

16. After his fall, respondent was off work for a few months and then gradually went back to light duty work. Approximately two years after his fall, he attended three accommodation meetings with the City. During the third meeting, the City told him it could not accommodate his restrictions and that he should pursue disability retirement. Respondent wanted to return to work, but the City would not let him.

Respondent's Medical Records

17. Respondent did not call an expert witness to testify on his behalf, but he submitted medical reports from his workers' compensation case, which were admitted as administrative hearsay and have been considered to the extent permitted under Government Code section 11513, subdivision (d).[4]

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[4] Government Code section 11513, subdivision (d), in relevant part, provides:

> Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions.

18. Moola P. Reddy, M.D. Dr. Reddy is board-certified in Physical Medicine and Rehabilitation and Electrodiagnostic Medicine. He performed a QME examination on respondent on December 18, 2013, reviewed respondent's medical records, and issued a report dated January 14, 2014. After examining respondent, Dr. Reddy diagnosed him as follows:

1. Chronic lumbar pain
2. L1 compression fracture and secondary degenerative changes at T12 and L1
3. Lumbar spondylosis
4. Cervical strain/sprain
5. Cervical spondylosis
6. Status post left shoulder arthroscopic biceps tenotomy and tenodesis, subacromial decompression, AC joint resection, and rotator cuff repair with residual left shoulder pain.

19. Dr. Reddy opined that respondent would not benefit from vertebroplasty for his chronic compression deformity of this L1 vertebral body. Dr. Reddy did not opine about respondent's disability status, impairment rating, causation, apportionment, work restrictions, work status, or future medical care.

20. Steven J. Barad, M.D. Dr. Barad is board-certified in orthopedic surgery. Respondent submitted a Permanent and Stationary Report from Dr. Barad dated February 19, 2014. In this report, Dr. Barad opined with regard to respondent's left shoulder. On May 6, 2013, based upon an MRI and clinical evaluation, Dr. Barad diagnosed respondent with "acromioclavicular arthrosis and a rotator cuff tear." Dr. Barad recommended surgery, which was performed on July 23, 2013, and consisted of a decompression of respondent's shoulder, a rotator cuff repair, a subpectoral biceps tenodesis, and an acromioclavicular joint resection. Respondent's condition improved, but he still complained of pain, primarily along the biceps tendon insertion. Respondent received an "injection anteriorly which helped him in the region of his pain." At the time of Dr. Barad's report, respondent had "modest" shoulder pain, but also complained of "significant headaches, upper back aches, and various other complaints." Dr. Barad opined that respondent was permanent and stationary and at maximum medical improvement with regard to his left shoulder.

21. Dr. Barad found that respondent's left shoulder had "very good motion and very good strength." Consequently, Dr. Barad found that there were "no ratable factors of disability that can be attributed to a deficit in this area." Dr. Barad found, however, that respondent had "permanent impairment" as a result of his acromioclavicular resection, giving him a 10 percent upper extremity impairment and a 6 percent whole person impairment. Due to respondent's continued pain in his shoulder, Dr. Barad thought that respondent would not be able to go back to his usual and customary duties. Dr. Barad allowed respondent to lift, pull and push "only up to about 20 pounds with the left upper extremity."

22. Stephen P. Abelow, M.D. Respondent submitted a Complex Comprehensive Medical Evaluation signed by Dr. Abelow on April 20, 2014.[5] Respondent was 55 years old at the time of the evaluation. After examining respondent and reviewing his medical records, Dr. Abelow diagnosed respondent as follows:

1. Concussion and postconcussive syndrome and headaches.
2. Cervical spine sprain and strain.
3. Left shoulder sprain and strain with impingement, AC joint arthritis, rotator cuff tear, and bicipital tendinitis.
4. Lumbar spine contusion, sprain, and strain with history of old compression fracture of L1 vertebra.

Dr. Abelow found that respondent's left shoulder condition was permanent and stationary by February 9, 2014, and that his other conditions were permanent and stationary by April 1, 2014. Dr. Abelow noted respondent's subjective complaints of pain and tenderness. He listed respondent's "objective disability factors" as follows:

> Tenderness cervical spine; diminished range of motion cervical spine; paracervical spasm; MRI findings of multilevel degenerative cervical disc disease and spinal stenosis.
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> Surgical scars left shoulder; tenderness left shoulder; diminished range of motion left shoulder; impingement sign positive left shoulder; resection of AC joint (distal clavicle); rotator cuff repair; weakness of left rotator cuff.
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> Tenderness low back; diminished range of motion lumbar spine; paralumbar spasm; MRI evidence of multilevel degenerative lumbar disc disease and prior compression fracture of L1.

Dr. Abelow opined that, "from an orthopedic standpoint," respondent then experienced "a disability referable to his cervical spine and left upper extremity combined which is a disability precluding heavy lifting greater than 20 pounds and repetitive pushing, pulling, grasping, pinching, holding, and torquing." Dr. Abelow also opined that respondent experienced a "disability referable to his lumbar spine which is a disability precluding heavy lifting greater than 30-40 pounds except on an occasional basis and repetitive, prolonged lifting, bending, stooping, pushing, pulling, and climbing." Dr. Abelow concluded that "these restrictions would preclude [respondent] from returning to his customary and usual job" as a Construction Inspector II, but respondent "may work full time as a parking machine repairman for the City."

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[5] Respondent could not find the first page of Dr. Abelow's report. The report was received in evidence without the first page.

23. Martin Shaffer, Ph.D. On May 9, 2014, Dr. Shaffer conducted a Neuropsychological Agreed Medical Examination (AME) of respondent, reviewed respondent's medical records, and issued a report in respondent's workers' compensation case. The focus of Dr. Shaffer's AME was whether respondent sustained an injury to his brain from his July 11, 2012 fall down the stairs. After examining respondent and reviewing the results of his cognitive and psychological testing, Dr. Shaffer diagnosed respondent with "Cognitive Disorder, NOS (294.9) mild" and "R/O Organic Mood Disorder (293.83) very mild."[6] As to respondent's ability to perform his job duties, Dr. Shaffer opined:

> In regard to the issue as to whether or not [respondent] can return to his usual and customary job, I don't see any difficulties with his doing inspections, conducting the inspections or observing work in progress. I think he is able to acquire new information and apply city standard specifications. From a functional standpoint, the biggest potential problem has to do with the fact that he has to have the ability to use computer programs applicable to the work. According to [respondent], he has had difficulty with the limited use of the previously familiar software programs and computer programs. Interpersonally I believe he can manage the requirements of the job.

Discussion

24. When all the evidence is considered, respondent failed to offer sufficient competent medical evidence to establish that, at the time he applied for disability retirement, he was substantially and permanently incapacitated from performing the usual duties of a Construction Inspector II for the City. Dr. Henrichsen's opinion that respondent was not substantially incapacitated from performing his usual job duties was persuasive. Although respondent criticized Dr. Henrichsen's examination as inadequate, particularly Dr. Henrichsen's failure to take and review any new x-rays or MRIs, Dr. Henrichsen's IME report was detailed and thorough, and his testimony at hearing was clear and comprehensive. The results of his physical examination and his review of respondent's medical records supported his opinion.

25. The burden was on respondent to offer sufficient competent medical evidence at hearing to support his disability retirement application. He failed to do so. He did not call an expert witness to testify. There was no indication in the medical reports respondent offered at hearing that the doctors who authored those reports evaluated respondent according to the standards applicable to a CalPERS disability retirement proceeding. To the extent the doctors applied evaluation standards applicable in workers' compensation cases, their opinions can be given little weight. The standards in CalPERS disability retirement cases are different from those in workers' compensation. (*Bianchi v. City of San Diego* (1989) 214 Cal.App.3d 563, 567; *Kimbrough v. Police & Fire Retirement System* (1984) 161

[6] "R/O" stands for rule out.

Cal.App.3d 1143, 1152-1153; *Summerford v. Board of Retirement* (1977) 72 Cal.App.3d 128, 132 [a workers' compensation ruling is not binding on the issue of eligibility for disability retirement because the focus of the issues and the parties are different].) The findings in Dr. Reddy's, Dr. Barad's, Dr. Abelow's and Dr. Shaffer's reports summarized above were insufficient to support that respondent is substantially and permanently incapacitated from performing the usual duties of a Construction Inspector II.

26. In sum, because respondent failed to offer sufficient competent medical evidence at the hearing to establish that, at the time he applied for disability retirement, he was substantially and permanently incapacitated from performing the usual duties of a Construction Inspector II for the City, his disability retirement application must be denied.

LEGAL CONCLUSIONS

1. By virtue of respondent's employment as a Construction Inspector II for the City, respondent is a local miscellaneous member of CalPERS, subject to Government Code section 21151.[7]

2. To qualify for disability retirement, respondent had to prove that, at the time he applied, he was "incapacitated physically or mentally for the performance of [his] duties." (Gov. Code, § 21156.) 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 court in *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 855, 863, explained that prophylactic restrictions that are imposed to prevent the risk of future injury or harm are not sufficient to

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[7] Government Code section 21151, in relevant part, provides:

> (a) Any 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.
>
> (b) This section also applies to local miscellaneous members if the contracting agency employing those members elects to be subject to this section by amendment to its contract.

support a finding of disability; a disability must be currently existing and not prospective in nature. In *Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, the court found that discomfort, which may make it difficult for an employee to perform his duties, is not sufficient in itself to establish permanent incapacity. (See also, *In re Keck* (2000) CalPERS Precedential Bd. Dec. No. 00-05, pp. 12-14.)

4. When all the evidence in this matter is considered in light of the analyses in *Mansperger, Hosford, Smith*, and *Keck*, respondent did not establish that his disability retirement application should be granted. He failed to submit sufficient evidence based upon competent medical opinion that, at the time he applied for disability retirement, he was permanently and substantially incapacitated from performing the usual duties of a Construction Inspector II for the City. Consequently, his disability retirement application must be denied.

ORDER

The application of respondent Andrew J. Borovansky for disability retirement is DENIED.

DATED: July 27, 2016

DocuSigned by:
Karen Brandt
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KAREN J. BRANDT
Administrative Law Judge
Office of Administrative Hearings