ATTACHMENT C

RESPONDENT'S ARGUMENT REGARDING THE PETITION FOR RECONSIDERATION
COVER SHEET

Respondent's Argument Case No.2016-0390

Attention: Calpers Board Secretary Cheree Swedensky.

The following is the Respondent Argument of Brooke R. Moore. It contains 17 pages.
Respondent's Argument

I, Brooke Moore, Respondent, would like to start off by saying that not only has this injury affected me physically, but emotionally, psychologically, and mentally. The negative impact that my "left ankle injury" has had on my life has been unbearable. I am not the same person I was before my injury. I can no longer run. I can no longer walk for very long without being in excruciating pain. I now suffer from depression, anxiety, panic attacks, PTSD, and suicidal thoughts. In my Petition for Reconsideration of my case, I would like to include copies of the medical documentation and records that I have received from my Doctors. I would also like to request that the Board take into consideration my Psychological Disability status in addition to my physical disability. This having been my first time applying for any kind of disability I was unaware of how detailed I should have been in my initial application. I made the mistake of thinking that "left ankle injury" would include all my conditions (physical/psychological) from this injury. The following Exhibits are my medical records and there will be Exhibit A-D. In conclusion to my Request, I just want to say that I have been declared disabled by three different doctors, including my Calpers issued Independent Medical Evaluation (IME) Dr. Daniel D'Amico. Shortly after his initial approval of my Disability retirement, Calpers forced Dr. D'Amico to remove medically documented facts from my medical history, that he, Dr. D'Amico, reviewed and determined that I am disabled. Thank you for your time and consideration of my case.
Exhibit Index

Exhibit A: Copies of pages 4, 8-10, and page 13 of Dr. Paul F. Clayman's (AME) report and medical evaluation.

Exhibit B: Copies of pages 12 and 13 of my Panel QME psychiatric evaluation by Dr. Hosein Tahami.

Exhibit C: Copies of pages 3 and 4 of the judgement made by Heather M. Rowan, Administrative Law Judge.

Exhibit D: Copies of Dr. D'Amico's initial response to my condition and a copy of his revised answers after Calpers made him take out facts from my medical records.
EXHIBIT A
Following my interview, I opined that Ms. Moore was suffering from:

1) status post Grade-3 sprain of the left ankle with anteromedial osteochondral injury to the dome of the talus, May 2, 2011;
2) status post left ankle arthroscopy with removal of osteochondral fragment; partial synovectomy; chondroplasty with curettage of defect and capsulorrhaphy for stabilization, February 22, 2012;
3) signs and symptoms of post-traumatic osteoarthritis of the left ankle mortise secondary to Nos. 1 & 2;
4) signs and symptoms of incisional neuroma of the dorsolateral sensory nerve to the left foot;
5) psychodynamic factors deriving from and contributing to musculoskeletal pain;
6) deconditioning of the musculoskeletal system deriving from all the above and contributing to musculoskeletal pain.

INTERVAL HISTORY

Ms. Moore is now 28 years old and she continues to experience pain and limitations in her left ankle.

She hasn’t participated in physical therapy for about a year. “It helped with movement originally, but it didn’t have any effect on weight bearing on that ankle”, so they discontinued it.

She saw Mr. Gary McCorkle, the PAC to Dr. Ushiba, about once a month to renew the prescription for pain medications. On January 24 and February 26, 2013, a request for a foot/ankle specialist consultation was provided by Mr. McCorkle, complying with my recommendation from the December 19, 2012 evaluation. “Also, with my loss of income and the Workers’ Comp taking so long, I went to my own doctor, Janine Bourelle, MD, and now take an anti-depressant,” Viibryd.

On May 22, 2013, Ms. Moore underwent a Panel QME psychiatric evaluation by Dr. Hosein Tahami. Dr. Tahami diagnosed: an adjustment disorder with depressed and anxious mood; depressive disorder, NOS; ADHD by history; chronic pain with physical limitations and financial hardships. Dr. Tahami felt that she was not P&S but he did recommend psychiatric care and indicated that permanent psychiatric disability was not anticipated. He also suggested that psychotropic medications would probably be helpful and stated: "needless to say, that the sooner treatment is offered, the better the prognosis."
management, home exercise program, follow-up with Dr. Varav. Restricted duty.


**IMPRESSION**

1. Status post Grade 3 sprain of the left ankle with anteromedial osteochondral injury to the dome of the talus, May 2, 2011;

2. Status post left ankle arthroscopy with removal of osteochondral fragment; partial synovectomy; chondroplasty with curettage of defect and capsulorraphy for stabilization, February 22, 2012;

3. Signs and symptoms of post-traumatic osteoarthritis of the left ankle mortise secondary to Nos. 1 & 2;

4. Signs and symptoms of incisional neuroma of the dorsal lateral sensory nerve to the left foot;

5. Psychodynamic factors deriving from and contributing to musculoskeletal pain;

6. Deconditioning of the musculoskeletal system deriving from all the above and contributing to musculoskeletal pain.
DISCUSSION

When I first saw Ms. Moore on December 19, 2012, she presented as a 27-year-old, right-handed woman with pain in the left ankle that had resulted from an injury on May 2, 2011, while working for Salinas Valley State Prison.

Ms. Moore is now 28 years old and she continues to experience pain in her left ankle, albeit slightly improved.

In my opinion, Ms. Moore is a failure of the Workers' Compensation system at multiple levels. I have no idea why an orthopedic foot specialist consultation was never arranged and provided as per my recommendation. This consultation was requested in every follow-up note from Dr. Ishizue's office since January 24, 2013 to the present. (Perhaps the proper authorization RFA-forms had not been submitted.) In addition, there was no indication that my recommendation for a cortisone injection was ever identified or considered. In fact there is no indication that she was seen by Dr. Ishizue over the past year but rather by his physician's assistant. It does not appear that these treatments were even sent to the utilization review to seek authorization.

In addition, Ms. Moore was provided a psychiatric assessment by Dr. Hosein Tahami on May 20, 2013. Unfortunately, there is no indication of any follow-through with Dr. Tahami's recommendations for psychological supportive counseling. She was given a prescription by her family practitioner for an antidepressant but that was the only change in her treatment over the past 12 months.

From my perspective, I still believe that the foot specialist consultation is warranted to help in determining the direction and course of her future care. It is highly likely that Ms. Moore will develop symptomatic posttraumatic osteoarthritis which may require more aggressive treatment in the not-too-distant future. Whether a simple arthroscopic débridement or chondroplasty could be helpful at the present time is the question I was seeking from the foot & ankle orthopedic specialist.

In my opinion, a cortisone injection may still be useful for treatment and diagnostic assessments.
About 4 weeks ago, I had requested a new set of standard x-rays but Ms. Moore indicated that she did not receive the paperwork and the x-rays were not done. I will order these x-rays and submit a supplemental report as soon as I receive and review the films.

**DISABILITY STATUS**

Ms. Moore can be considered MMI as of today for the purposes of rating. However, she still requires further services as previously recommended. These services and care can be rendered as future medical benefits.

On the other hand, if the foot specialist consultant recommends specific treatment modalities and/or surgery then she should return to TTD status until that physician renders her P&S.

**SUBJECTIVE FACTORS OF PERMANENT DISABILITY**

There is "slight" improvement of Ms. Moore's current symptoms, mainly in the frequency of her pain experience. In my opinion, the intensity of her pain is still characterized as mild to moderate with weight-bearing activities sometimes requiring Norco and/or unweighting her left ankle for relief. For the most part she has developed a congenial lifestyle to avoid experiencing activity-limiting-pain.

Attached to this report is the copy of the patient's pain drawing that I am submitting as a graphic representation of the quality, character, and location of her symptoms.

**OBJECTIVE FACTORS OF PERMANENT DISABILITY**

1. There is tenderness to palpation at the anterior medial and lateral talotibial articulation and anterolateral ligaments of the left ankle.

2. There was x-ray and arthroscopic observation of an osteochondral defect on the dome of the talus and a bone spur on the anterolateral margin of the tibia.

3. There is a very slight loss of dorsi-flexion at the left ankle mortise compared to the normal right ankle; there is also a slight loss of eversion on the left subtalar joint compared to the right.
3. A cortisone injection to the left ankle would be helpful for diagnostic and therapeutic observation but this treatment should be left to the discretion and judgment of the consultant.

4. Encourage self-directed exercises as instructed by the physical therapist.

5. Self regulated use of proprietary nonsteroidal anti-inflammatory medications and/or analgesics is reasonable.

APPORTIONMENT

Apportionment is not indicated. In my opinion, 100% of her current disability is the result of the above claimed injury and the consequences deriving therefrom.

RETURN VISIT

None was given. The patient was seen for evaluation only.
seek treatment. She was eventually provided with an antidepressant which led to significant improvement in her depression and anxiety.

Fortunately there has been significant improvement in Ms. Moore's depression, anxiety and mood symptoms since the last evaluation. Such improvement can be attributed primarily to the current treatment that she is receiving including pharmacotherapy and group therapy. Ms. Moore is currently not voicing any significant complaints. She wishes to continue with the current treatment which has been quite efficacious.

With regards to causation my opinion remains the same as detailed in my original report dated May 20, 2013. It is my understanding that this case has been accepted as AOE/COE and treatment offered but not secured on industrial basis, therefore, I will not elaborate any farther on the issue of causation. With regards to apportionment, 10% can be apportioned to nonIndustrial factors with 90% arisen as a result of and in the course of employment the department of corrections.

PERMANENT AND STATIONARY STATUS:

Ms. Moore can now be viewed as having gained maximum medical improvement and therefore permanent and stationary.

SUBJECTIVE FACTORS:

Some mild residual anxiety.

OBJECTIVE FACTORS:

None.

FACTORS OF DISABILITY:

The following disability rating is based on AMA guidelines, this can be found in chapter 14 of the Guides to the Evaluation of Permanent Impairment Fifth Edition.

1. Activities of daily living. Such activities include self-care, personal hygiene, communications, ambulation, travel, sexual function and sleep. Ms. Moore has no difficulty with personal hygiene and is able to adequately care for self and communicate her needs. She has some difficulty with sleep which predates injury, however, there has been no change in libido. She is able to travel as she wishes. Therefore, there is no impairment in this category.
2. **Social functioning.** Such refers to individual capacity to interact appropriately, get along and communicate effectively with others. Ms. Moore has been able to associate with friends and family as well as in the past. She remains outgoing and engaging. Therefore, there is no impairment in this category.

3. **Concentration, persistence and pace.** Such are needed to perform many activities of daily living including task completion. Ms. Moore was able to concentrate on questions and provide appropriate answers. She denies any problems with concentration and focus. Her persistence and pace has also improved with improvement in her energy level and sleep. Therefore, there is no impairment in this category.

4. **Deterioration or decompensation in complex or work-like settings.** Such refers to individuals repeated failure to adapt to stressful circumstances. In place of stressful circumstances, the individual may withdraw from this situation and experience signs and symptoms of mental disorder. Such has been the case in the case of Ms. Moore, therefore, her impairment in this category is best categorized as class 2, mild impairment. Ms. Moore is currently has been assigned GAP score of 80, which corresponds to the Whole Body Impairment Rating of 0%.

**FUTURE MEDICAL/PSYCHIATRIC TREATMENT:**

Recommendations with regards to psychiatric treatment remain the same as detailed in the previous report. Provisions for future psychiatric treatment is indicated. She should be provided with treatment in the form of medication management and psychotherapy in order to ensure continuing progress and prevent potential relapse. She has responded well to Vobryd, therefore, the medication should be authorized for another year. The treating psychiatrist and the claimant will agree upon a timeline when the claimant can be tapered off Vobryd. Should she experience recurrence of symptoms after initial tapering off, then she may be in need of antidepressant treatment for prolonged period.

Please not hesitate to contact me at the above address should you have any questions or concerns regarding this case.

Pursuant to Labor Code Section 5703, the following statement is made: I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as the information that I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, except as noted herein, that I believe to be true. I have not violated Labor Code Section 139.3. This examination took place at 2121 North Main Street, Salinas, CA. This constitutes MI-104 Extraordinary Medical Legal Evaluation. Based on administrative regulation at 9794 (c)(1) the original procedure codes used by the physician or other providers shall not be altered. Labor Code section 4603.2 (b) mandates payments for medical legal reports within 45 days of receipt of such report.
Disarm, subdue, and apply restraints to an inmate;
Defend self against an inmate armed with a weapon;

Walk occasionally to continuously;

Run occasionally; run in an all-out effort while responding to alarms or serious incidents, distances ranging from a few yards to up to 400 yards and may take place on varying, uneven surfaces; may include stairs;

Climb occasionally to frequently, ascent/descent or climb a series of steps/stairs or ladders, as well as climb onto bunks/beds; must be able to carry items while climbing stairs;

Lifting and carrying in the light to medium range (20 to 50 pounds) frequently throughout the workday and in the very heavy range (100 pounds or more) occasionally. This could include physically restraining or wrestling an inmate to the ground as well as partially lifting and dragging an inmate; and

Pushing and pulling occasionally to frequently, which could include restraining an inmate.

**Expert Opinion**

6. CalPERS retained Daniel D'Amico, M.D. to conduct an Independent Medical Evaluation (IME) of respondent. Dr. D'Amico is a board-certified orthopedic surgeon. Dr. D'Amico examined respondent on December 9, 2015, took respondent's medical history, reviewed respondent's medical records, and prepared an IME report.

7. Respondent explained to Dr. D'Amico that she injured her left ankle on May 2, 2011, when she responded to an alarm on the prison yard while on duty as a Correctional Officer. After her injury, respondent was evaluated by a doctor and was treated conservatively with pain medication and physical therapy. In February of 2012, respondent had “lateral capsulotomy” surgery on her ankle and was diagnosed with a grade three sprain. She did not return to work after the date of injury.

8. Respondent's pain continued, and worsened, following surgery. She began wearing a boot, but continued experiencing pain. From Dr. D'Amico's review of respondent's medical history, he opined that the surgery worsened respondent's condition. Dr. D'Amico reported that respondent felt the ankle was unstable as well as stiff. In his opinion, this is not possible. He testified that it is “incompatible to have lateral instability and stiffness.” He later said that it is possible, but the way that she described her pain and instability did not make sense to him. Additionally, the surgeon who performed respondent's ankle surgery was not clear on the connection between the actual pain respondent
experienced from the injury and what the surgery would do to correct that pain. The surgery did not correct respondent's pain, and possibly made it worse. Without seeing the ligament in an MRI, however, Dr. D’Amico could not say for certain whether it had healed. Based on his examination of respondent, he did not find a high degree of instability.

9. In Dr. D’Amico’s IME report, he noted that respondent could wear a boot on her left foot and perform her job duties. She would also need to limit her activities. Over time, she would need to recondition herself so that she would be fully rehabilitated to perform as a Correctional Officer.

10. During the course of her treatment, respondent was referred to mental health doctors to treat her anxiety, depression, and mood symptoms. Dr. D’Amico reviewed respondent’s psychiatrist’s report, in which the psychiatrist opined that respondent’s psychiatric condition and pain were interrelated. Dr. D’Amico agreed. He testified that respondent was disabled, “from a psychiatric point of view.” Additionally, a psychiatric condition such as depression or anxiety can cause a person to experience increased pain. In his initial IME report, Dr. D’Amico found that respondent was substantially incapacitated from performing the usual duties of a correctional officer on the basis of her psychological conditions. CalPERS requested that he reissue his report and limit his findings to his expertise as a board-certified orthopedic surgeon. In response to CalPERS’s request, Dr. D’Amico issued a revised report dated January 27, 2016, in which he opined that respondent was not substantially incapacitated on the basis of an orthopedic ankle injury. He deleted from his report all conclusions based upon her psychiatric condition.

Respondent’s Evidence

11. At the hearing, respondent testified about her work and injury history. She was a Correctional Officer with the Department for four or five years. On May 2, 2011, she responded to an alarm at work, ran across a dirt yard, and her foot fell into a hole. She twisted her ankle and fell. She has not returned to work. She testified that the Department requires Correctional Officers to wear a specific uniform and she is not able to wear a “walking boot” at work. Additionally, a Correctional Officer may not use prescribed pain medication while on duty.

12. Respondent agreed with the duties of a Correctional Officer as described above. Salinas Valley State Prison is a “Level 4” prison, which is a prison that has the highest level of security. Respondent described the prison as being busy with daily incidents to which the officers must respond. Depending on the incident, officers must run at full speed, climb stairs, take down inmates, or protect themselves against inmates.

13. Respondent described the medical treatment she received since her work injury. She has seen four or five doctors. She has been told that her pain is in her head. The surgery performed on her ankle made the pain worse. When she saw doctors to try to address the cause of her pain, she was accused of being “drug seeking” and prescribed pain medication rather than receiving treatment. The increasing instability in her ankle has caused
DISCUSSION

Based on the history, first of all the initial x-ray on the day of injury documented a previous existing condition in the dome of the talus. She did not cause the injury to the dome of the talus by her twisting injury. This is documented. No one apparently looked at the x-rays or read the report. The other issue is that she did have a sprain based on the clinical history. The other documentation is that healed well. She did not have instability, although she claimed it, and all the doctors' records state she was both stiff and unstable at the same time. This is a contradiction and cannot exist. During the course of my evaluation, she had some slight loss of mobility, no swelling, no edema, and no skin or tissue changes. She had no loss of strength.

Based on Dr. Ushiba's findings, Ms. Moore had an osteochondral lesion which pre-existed this injury. It was treated adequately. No one had bothered to take any recent x-rays to see if there have been any arthritic changes in the ankle. No one has done a stress x-ray, and no one has done a repeat MRI. Therefore, based on my physical findings, I believe that Ms. Moore has a somatoform pain disorder and that her orthopedic problems in her ankle do not disable her from performing her duties. She can be given some slight restrictions, wear a boot, and I do not feel the physical findings make her disabled. I feel her disability, as has been suspected by her treating physician's, is a psychosomatic or a somatoform pain disorder.

ANSWERS TO SPECIFIC QUESTIONS.

1. Are there specific job duties you feel the member is unable to perform?

   Yes, she cannot run 400 yards and run up or down stairs, because of her subjective pain and deconditioned state.

2. In your professional opinion, is the member presently substantially incapacitated?

   Not from an orthopedic point of view. She can rehabilitate her left ankle. From a psychophysiologic point of view it has been indicated she is disabled. This is the opinion of the psychiatrist that I reviewed.

   Disability began on the day of the injury 5/2/2011, however, she was always released to limited duty and never returned to work. We really have no accurate data when the disability began. Based on the first x-ray, she had a preexisting lesion on the dome of the talus, which is documented the day of the injury and this by nature of the x-ray preexisted that particular date. She then had a grade 3 sprain of the ankle which went on to heal based on all the physical findings of Dr. Ushiba and all of the physical findings that I have made at the time of my examination.
distribution, no coolness, no moisture, no sweating, and no findings that would indicate she had any of the eight of the physical findings that are indicated in the AMA Guidelines for sympathetic reflex dystrophy or CRPS.

Based on her strength, Ms. Moore had good strength in plantarflexion against resistance and good dorsiflexion range as well.

**DIAGNOSIS**

1. Chronic sprain Class III (anterior talo-fibular ligament), healed
2. Post-surgery foot & ankle as described in records
3. Osteochondral lesion of talus, healed and stable
4. Somatoform pain syndrome, right foot and ankle

**DISCUSSION**

Based on the history, first of all the initial x-ray on the day of injury documented a previous existing condition in the dome of the talus. She did not cause the injury to the dome of the talus by her twisting injury. This is documented. No one apparently looked at the x-rays or read the report. The other issue is that she did have a sprain based on the clinical history. The other documentation is that healed well. She did not have instability, although she claimed it, and all the doctors' records state she was both stiff and unstable at the same time. This is a contradiction and cannot exist. During the course of my evaluation, she had some slight loss of mobility, no swelling, no edema, and no skin or tissue changes. She had no loss of strength.

Based on Dr. Ushiba's findings, Ms. Moore had an osteochondral lesion which pre-existed this injury. It was treated adequately.

**ANSWERS TO SPECIFIC QUESTIONS**

1. Are there specific job duties you feel the member is unable to perform?

   No, I believe she can perform all of the job duties based on the lack of physical findings and based on my physical examination.

2. In your professional opinion, is the member presently substantially incapacitated?

   No, any tissue problems can be rehabilitated. Disability began on the day of the injury 5/2/2011, however, she was always released to limited duty and never returned to work. We really have no accurate data when the