BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Application for Industrial Disability Retirement of:

CAROLE M. ALLEN,
Respondent,

and,

VALLEY STATE PRISON FOR WOMEN,
CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION,
Respondent.

PROPOSED DECISION

This matter was heard before Danette C. Brown, Administrative Law Judge, Office of Administrative Hearings, State of California, on August 30, 2017, in Fresno, California.

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

Carole M. Allen (respondent) appeared and was represented by Thomas J. Tusun, Attorney at Law.

No appearance was made by or on behalf of respondent Valley State Prison for Women (VSPW), Department of Corrections and Rehabilitation (CDCR). Accordingly, the matter proceeded as a default against respondent VSPW, pursuant to Government Code section 11520.

Evidence was received, the record was closed, and the matter was submitted for decision on August 30, 2017.

1 Valley State Prison for Women is now known as Valley State Pris...
ISSUE

Based upon respondent’s podiatric (left ankle) condition, is respondent permanently disabled or substantially incapacitated from performing the usual duties of a Registered Nurse for VSPW?

FACTUAL FINDINGS

Duties of a Registered Nurse

1. At the time of her application for industrial disability retirement, respondent was employed as a Registered Nurse (RN) for VSPW. The RN Essential Functions List describes the administrative and physical functions of the job. In general, the RN provides direct and indirect nursing care to inmate patients. The RN “must always be ready, willing and able to perform all of the essential functions.” (Italics in original.)

2. The physical functions of the job include:

   • Have and maintain sufficient strength, agility and endurance to perform during stressful (physical and mental and emotional) situations without compromising health and well-being of self or others;

   • Remain sufficiently alert and focused to effectively evaluate and respond to dangerous or emergency situations;

   • Move about the institution occasionally to continuously covering long distances indoors or outdoors in various weather conditions;

   • Access all floors of facilities with multiple levels separated by flights of stairs;

   • Remain stationary occasionally to continuously while keeping records, writing reports, observing designated areas, and performing other nursing tasks;

   • Stoop, bend, reach, twist, and stretch occasionally to continuously, sufficiently to inspect, observe, manipulate, move and record objects 360 degrees horizontally or more from floor through overhead levels;
• Lift and carry frequently light (20 pound maximum) to medium (50 pound maximum) loads;

• Lift and carry occasionally to frequently very heavy (over 100 pounds) loads for example when preventing patient from falling;

• Pushing and pulling occasionally to frequently;

• Perform regular duties on a wide range of working surfaces which may be uneven or rough or become slippery due to weather or spillage of liquids.

(Punctuation added.)

3. VSPW completed, and respondent signed, a CalPERS* document entitled, “Physical Requirements of Position/Occupational Title,” for respondent’s position as an RN. The job requires respondent to occasionally (up to three hours): kneel; squat; reach above her shoulders; keyboard; lift 0 to 100 pounds; work with heavy equipment; work at heights; and operate foot controls. Respondent occasionally to frequently (three to six hours): climbs; pushes and pulls; walks on uneven ground; is exposed to extreme temperature, humidity and wetness; and is exposed to dust, gas fumes or chemicals. Respondent occasionally to constantly (over six hours): sits; stands; walks; and performs fine manipulation. Respondent constantly engages in the repetitive use of her hands.

Respondent’s Employment History

4. Respondent began her state employment as an RN at VSPW. Her last day of work was on September 30, 2015. On March 24, 2016, respondent submitted an application for service retirement pending industrial disability retirement (application). She retired for service effective September 26, 2016, and has been receiving her retirement allowance from that date. By virtue of her employment, respondent is a state safety member of CalPERS subject to Government Code section 21151.

Respondent’s Disability Retirement Application

5. On March 28, 2016, CalPERS received respondent’s application in which she described her specific disability as “[F]ractured left ankle[,]” She stated that her disability occurred, “[w]alking to Medical from Delta Yard Clinic.” Respondent described her limitations/preclusions due to her injury as “unable to walk rapidly at all – unable to walk more than 2 hours.” She also wrote that her injury has affected her ability to perform her job as follows:
After walking for a few hours there is severe pain preventing further walking on [left] foot.

6. On June 29, 2016, Anthony Suine, Chief of the Benefit Services Division, notified respondent that her application had been denied based upon a finding that her podiatric (left ankle) condition was not substantially incapacitating. Respondent timely appealed from the denial.

Respondent’s Injuries, Treatment and Assistance

7. On September 14, 2015, respondent injured her left foot at work when she stepped on a “pebble” while walking to the administration building. Her left foot rolled inward. Respondent experienced pain, but continued walking. She finished her workday, assessing 15 to 20 patients, and took vital signs while standing. Respondent went home, but did not treat her pain. Her pain increased daily. On September 30, 2015, respondent’s pain began making her nauseous. She thought she broke a bone, and sought medical attention. An x-ray showed a break in the “medial malleolus.” Respondent’s left foot was placed in a boot. She contacted her workplace, and was told that she could not return to work with a boot, and needed a medical clearance.

8. Respondent was treated by Michael Azevedo, M.D., at Kaiser Permanente in Fresno. An x-ray of respondent’s left ankle was taken, showing “bony irregularities of the medial malleolus” related to old trauma. There was “no appreciable left ankle fracture or dislocation.” Dr. Azevedo instructed respondent to be non-weight-bearing (NWB), and to elevate and ice her foot. Respondent saw Dr. Azevedo every two weeks, and was referred to physical therapy. Her first two sessions went well and she underwent electrical nerve stimulation and ultrasound. On the third visit, however, after riding a stationary bicycle for three minutes, respondent experienced pain she described as ranging from 4-5 to 8-9 on a 10-scale.

9. On December 18, 2015, another x-ray showed no changes in respondent’s left ankle. A small bony spur was noted to extend medially from the medial malleolus. A January 8, 2016 magnetic resonance image (MRI) of respondent’s left ankle showed the following impressions:

- Tendinosis and tenosynovitis of the posterior tibialis tendon
- Partial tear of the distal superomedial calcaneonavicular ligament of the spring ligament complex
- Chronic sprain of anterior talofibular and calcaneofibular ligaments
10. Respondent was referred to Thomas Kaschak, D.P.M. Dr. Kaschak administered an ankle injection in January 2016, which gave respondent “very good relief” for five to six days. Thereafter, respondent experienced intermittent sharp, stabbing pain. The pain worsened when respondent stood or walked, especially when she pivoted on her left foot.

11. On January 27, 2016, Dr. Kaschak recommended moldable orthotics. However, they were too hard and uncomfortable for respondent. Upon review of her latest x-ray and MRI, Dr. Kaschak diagnosed respondent with: a “[G]rade II lateral ankle sprain; PTTD, and possible avulsion fracture distal lateral malleolus.” Dr. Kaschak suggested casting respondent’s left foot, with a follow up in two to three weeks.

12. The following month, Dr. Azevedo evaluated respondent, who wore the cast for only one day. The cast was removed because respondent experienced pain over her lateral ankle and the arch of her foot. Respondent refused a knee scooter. Dr. Azevedo continued her medications of Norco, Relafen and Gabapentin.

13. A few months later, another cast was attempted. The following week, respondent’s toes became cold and the cast was removed, in the spring of 2016. Her lateral ankle soon began bothering her. She felt that her “ankle was collapsing on itself.” In February 2016, Kaiser conducted another MRI. Respondent recalled being told that her medial malleolus was “rough.” Respondent returned to wearing the boot, then finally settled on wearing Crocs, plastic clog-like shoes, which were helpful in allowing her foot to roll to the outside.

14. In April 2016, respondent still experienced disabling ankle pain and surgery was recommended. In July 2016, respondent resumed physical therapy but her pain was more severe, requiring her to take Gabapentin. She continued to complain of pain over the lateral aspect of her foot, which radiated to the anterior, or front part of her foot. In September 2016, Dr. Azevedo noted that respondent continued to complain of pain on the medial and/or lateral aspect of her left ankle. Upon examination, respondent had mild to moderate swelling. In February 2017, respondent had surgery on her left ankle to address bone spurs. She continues to experience pain when walking and standing for long periods of time.

CalPERS' Expert, Ekta Balani, D.P.M., F.A.C.F.A.S

15. Dr. Balani is a board-certified foot and ankle surgeon. On May 23, 2016, Dr. Balani conducted an independent medical examination (IME) of respondent at the request of CalPERS due to her injury on September 14, 2015. Dr. Balani reviewed respondent’s

\(^2\) Posterior Tibial Tendon Dysfunction.

\(^3\) Dr. Balani’s former legal name was Ekta Shah. She is identified as Dr. Balani in this decision.
medical, occupational and treatment history, performed a physical examination and prepared an IME report dated May 23, 2016. She followed up with a supplemental IME report dated December 8, 2016, after reviewing additional medical records. Dr. Balani’s testimony at hearing was consistent with her IME reports, in which she described respondent’s complaints at the time of the IME as follows:

She experiences a level of 3/10 pain in the morning when awake in bed. Once she stands, 90% time, the ankle feels like it is “falling apart”. Pain is worse on lateral side, 8-9/10 pain. Once she gets going/walking, pain level 3-5/10 on level ground. She is able to make breakfast and use restroom. After 2-3 hours of activity (doesn’t have to be consistent) she is “down for the day” with a 6-8/10 sharp, intense pain on the medial side. Sitting for long periods of time is difficult.

Medication does help and Norco seems to “numb her brain”, it keeps her from becoming depressed. Neurontin helps with the electric shock sensation after 3-4 days of use.

Pain today is 5/10 after 2.5 hours in the car as a passenger.

(Paragraph breaks in original.)

16. Dr. Balani’s physical examination consisted of vascular, neurological, dermatological and musculoskeletal examinations. Respondent’s vascular examination resulted in faint posterior tibial pulses on the right and left foot/ankle. Mild edema was noted on the left medial ankle. Respondent’s neurological examination revealed intact sensation on both feet, with increased sensation on the left medial and lateral ankle. Respondent’s dermatological examination showed that respondent’s skin was intact in texture, turgor and temperature within normal limits. Dr. Balani focused on respondent’s left ankle for the musculoskeletal examination. She noted:

- Pain with light touch to medial malleolus (exaggerated symptom while checking pulses)
- Extreme pain with inversion/eversion of left ankle
- Pain with palpation around the left medial ankle at deltoid ligament (though the same intensity of pain was not reproducible as first palpation caused)

Dr. Balani described respondent’s gait as “Mildly antalgic to normal gait.” She took angle measurements of respondent’s ankle joint in dorsiflexion, her subtalar joint in inversion and eversion, her midtarsal joint, her calcaneal eversion, and measurements of
respondent's calf, ankle and foot girth; she identified no concerns with any of respondent's measurements.

17. Dr. Balani's diagnosis and impression were as follows:
   a. Ankle sprain, left – RESOLVED
   b. Tendinosis of the posterior tibialis tendon, left
   c. Partial tear of the distal superomedial calcaneonavicular ligament of the spring ligament complex, left

18. Dr. Balani believed there were no specific job duties that respondent was unable to perform, based upon her objective findings. Dr. Balani believed that respondent suffered an ankle sprain, rather than a fracture of her medial malleolus. This was supported by the October 14, 2015 and October 28, 2015 x-ray reports. The MRI did not show any bone abnormality. Respondent's pain was near the "superomedial calcaneonavicular ligament (SMCN)" which was partially torn on the MRI. Dr. Balani opined that since respondent's posterior tibial tendon was not torn, it was unlikely that the sprain tore the SMCN ligament without affecting other structures. She further opined that respondent's foot type, severe calcaneal eversion, already placed an increased strain on the posterior tibial tendon, which was noted to have degeneration on the MRI, and the spring ligament complex.

19. Dr. Balani explained that the SMCN ligament is part of the spring ligament complex, and "functions with the inferior calcaneonavicular ligament (ICN ligament) to resist plantarflexion and adduction of the talar head during pronation. The spring ligament complex aids in the stability of the arch, along with the posterior tibial tendon." She further explained that respondent's injury inflamed the posterior tibial tendon, and the partially attached SMCN ligament. Respondent's foot type made healing of the inflammation more difficult due to the already increased strain "on these medial structures." At the time of the IME, approximately eight months after her injury, Dr. Balani expected resolution of the inflammation.

20. Dr. Balani concluded that respondent's posterior tibial tendon was not torn and demonstrated degeneration only, which was expected from her foot type. The tendon still functioned, and should have further helped the SMCN ligament pain to resolve. Dr. Balani stated:

   Even if it is not completely resolved owing to Ms. Allen's shoe gear choice and lack of biomechanical support from custom orthotics, I do not believe it would prevent her from doing her job duties.

21. Dr. Balani also concluded that respondent is not substantially incapacitated from the performance of her duties. She noted that respondent's subjective complaints did
not correlate with the objective IME or medical record findings. Respondent’s symptoms to
touch and foot movement seemed exaggerated for the type of injury she sustained. Dr.
Balani testified that respondent “absolutely could have benefitted” from custom orthotics,
which would have allowed respondent’s foot and ankle to heal, and allow the inflammation
to go away. In addition, the boot, with a custom orthotic, would have helped respondent by
immobilizing her foot. Dr. Balani stated, “In a situation like that, you want an orthotic in
the boot to prevent rolling to inside of the boot.” She explained, this would have alleviated
respondent’s complaint that her ankle touched the inside of the boot, causing her pain.

Respondent’s Expert, Timothy A. Van Dyne, D.P.M.

22. Dr. Van Dyne is a board-certified podiatric surgeon, and is board-certified in
podiatric medicine. On May 11, 2017, Dr. Van Dyne reviewed respondent’s medical
records, and performed a physical examination of respondent. Dr. Van Dyne testified at
hearing consistent with his admitted report dated May 11, 2017.

Dr. Van Dyne testified that Dr. Azevedo put respondent on sedentary duty and
provided nonsurgical treatment after her injury. Respondent then went to see Dr. Kaschak,
who began his conservative treatment of placing respondent in a boot, which caused her
increasing pain. Other various types of local conservative treatment did not work. Dr. Van
Dyne noted that respondent underwent surgery on February 13, 2017. Dr. Kaschack “went
into the lateral portion of the ankle which was having a significant amount of pain. He went
into the lateral gutter and cleaned out the area, then went into the fibula bone and cleaned
that. There could have been arthritic changes in the area.”

On the other side of respondent’s ankle, respondent’s tibialis posterior required
“debridement and cleaning out of the area.” Respondent stated that she had “recovered
reasonably well” from the surgery, and related that she had pain in her left foot along the
little toe side close to a surgical scar from her surgery. Respondent was able to perform a
limited amount of standing and walking, and Dr. Van Dyne noted that she was “able to
perform her usual duties.” However, when walking and standing was required for extended
periods of time, the pain in the lateral portion of respondent’s foot became more severe and
caused her to be more concerned about her foot pain rather than her duties.

23. A vascular examination of respondent’s left foot showed slight edema in the
lateral ankle area when compared with the right foot. A neurological examination revealed a
“somewhat diminished” Achilles tendon reflex on the left side. Compression of the lateral
scar caused a distal sensation of “tingling.” A musculoskeletal examination found normal
and symmetrical muscle mass and strength. Respondent’s hip and knee ranges were normal.
Her posterior tibial tendon was tender to palpation when hard tapping was applied. Her left
foot was more symptomatic than the right. Dr. Van Dyne noted, “This appears to be a
longstanding issue.”

24. Dr. Van Dyne’s impressions were as follows:
a. Posterior tibial tendon dysfunction.

b. Lateral column syndrome consisting of midtarsal joint capsulitis and peroneus longus tendinitis, left foot.

c. Status post ankle surgery and tendon repair, left foot.

Dr. Van Dyne opined that respondent's September 14, 2015 injury set off a series of foot dysfunctions which led to respondent's current issues. The partial tear of her spring ligament caused additional stress and problems associated with the tibialis posterior injury, from which respondent has not been able to fully recover. Surgical intervention helped to decrease the tibialis posterior pain and issues involving the movement of the tibialis posterior. X-rays showed a "plantar calcaneal and retrocalcaneal heel spur to be present" indicating the long term effect of her conditions. Dr. Van Dyne further opined:

Absent the injury, the patient could have been capable of full duty for many years with some minor biomechanical assistance. However once the injury to the tibialis posterior occurred, significant changes in her bodies [sic] capacity to compensate for the preexisting condition occurred. She is now no longer capable of running or long periods of standing or walking and she should refrain from stairs and steps as much as possible. Irregular surfaces must be avoided in order to avoid additional straining of the tibialis posterior tendon. Ordinarily, a brace compensating for the tibialis posterior dysfunction can be used. However, in the face of the tendo-Achilles equinus, the braces are not as effective and therefore, additional issues of friction injury to the skin and soft tissue overlying bony prominences is an issue.

Dr. Van Dyne opined that the IME reports of December 8, 2016 and May 23, 2016 were no longer valid because respondent had undergone surgical intervention which verified that she was having "issues that were denied in those reports." He concluded that respondent is no longer capable of performing the standing, walking and running requirements of her job. In his 41 years of podiatry practice, Dr. Van Dyne "had not yet seen anyone capable of returning to walking long distances or running after an injury to the spring ligament with tendo-Achilles equinus involvement." This was the first time that Dr. Van Dyne had seen an Achilles shortening and ligament tear together.

Discussion

Dr. Van Dyne distinguished his examination from Dr. Balani's, in that Dr. Balani examined respondent before her surgery. He stated that there was "no real good evidence yet that respondent's tibialis posterior tendon was damaged enough to debride." However, he opined that the "debridement" and "cleaning out" of respondent's ankle due to
bone spurs was the result of arthritic changes, not her injury. Dr. Van Dyne agreed that orthotics could work, "but her Achilles is so short." With respondent's "dysfunctional tibialis posterior, we were constantly getting orthotics back for adjustments, chasing the problem all over the place." Dr. Van Dyne believed that respondent's unique dual condition of her Achilles shortening and spring ligament tear would not have been remedied by orthotics. This was the first time that Dr. Van Dyne testified in a CalPERS hearing, and understood the CalPERS disability standard to mean that if "respondent is unable to perform her duties, then she cannot go back to that job, and is medically disabled."

27. Dr. Balani opined that respondent's flat foot played a role in her sprained ankle. Her flat foot put severe strain on her tibial tendon and spring ligament. Dr. Balani did not think, as did Dr. Van Dyne, that respondent's injury strained her ligament or tendon, but rather, the injury "irritated already existing conditions." She recognized Dr. Van Dyne's concern regarding respondent's tight Achilles tendon. An Achilles tendon is "expected to be tight with a severe flat foot." Dr. Balani asserted that "any and all orthotics lightly lift the heel to treat the Achilles tendon." She uses orthotics in her own practice, and believes that the right orthotics would resolve respondent's short Achilles tendon problem.

28. Dr. Balani credibly believed that "custom orthotics is the big miss here." She opined that orthotics should have been a treatment that was not implemented before or after surgery. In reviewing respondent's medical records, including the MRI, Dr. Balani believed that respondent could perform her job duties, given a custom orthotic. She explained that respondent's complaints of pain from rubbing against the boot could be resolved by proper padding.

29. Dr. Balani persuasively concluded that respondent is not permanently disabled or incapacitated from performing the usual duties of an RN. The above matters as well the medical record having been considered, respondent has not established through competent medical evidence that, at the time of application, she was permanently disabled or incapacitated from performing the usual duties of her position as an RN.

LEGAL CONCLUSIONS

1. Respondent has the burden of proof to establish by a preponderance of evidence that she is "incapacitated for the performance of duty," which courts have
interpreted to mean "the substantial inability of the applicant to perform his usual duties." (Mansperger v. Public Employees' Retirement System (1970) 6 Cal.App.3d 873, 877.) Discomfort, which may make it difficult to perform one's duties, is insufficient to establish permanent incapacity from performance of one's position. (Smith v. City of Napa (2004) 120 Cal.App.4th 194, 207, citing Hosford v. Board of Administration (1978) 77 Cal.App.3d 854, 862.) Furthermore, an increased risk of further injury is insufficient to constitute a present disability, and prophylactic restrictions on work duties cannot form the basis of a disability retirement. (Hosford, supra, 77 Cal.App.3d at p. 863.)

2. Pursuant to Government Code section 21150, members incapacitated for the performance of duty shall be retired for disability. Government Code section 20026 provides that "Disability' and 'incapacity for performance of duty' as a basis of retirement, means disability of permanent or extended and uncertain duration, as determined by the board . . . on the basis of competent medical opinion."

An applicant for disability retirement must submit competent, objective medical evidence to establish that, at the time of application, he or she was permanently disabled or incapacitated from performing the usual duties of his or her position. (Harmon v. Board of Retirement (1976) 62 Cal.App.3d 689, 697 [finding that a deputy sheriff was not permanently incapacitated from the performance of his duties, because "aside from a demonstrable mild degenerative change of the lower lumbar spine at the L-5 level, the diagnosis and prognosis for the [the sheriff's] condition are dependent on his subjective symptoms"]).


3. Mansperger, Hosford and Harmon are controlling in this case. The burden was on respondent to present competent medical evidence to show that, as of the date she applied for disability retirement, she was substantially unable to perform the usual duties of an RN due to her podiatric (left ankle) condition. Respondent failed to meet this burden. Her application for industrial disability retirement must, therefore, be denied.

applicable. Furthermore, Evidence Code section 664 creates the general presumption that a public agency has performed its official duty. Here, CalPERS has fulfilled its duty to determine respondent's eligibility for disability retirement, and the burden falls on respondent to rebut the presumption of Evidence Code section 664 by proving incapacitating disability.
ORDER

The application for industrial disability retirement filed by respondent Carole M. Allen is DENIED.

DATED: September 25, 2017

[Signature]

DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings