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:

MURIEL S. MCKENZIE,
Respondent,

and,

CALIFORNIA HIGHWAY PATROL,
Respondent.

Case No. 2017-0041
OAH No. 2017030582

PROPOSED DECISION

This matter was heard before Danette C. Brown, Administrative Law Judge, Office of Administrative Hearings, State of California, on October 9, 2017, in Sacramento, California.

Preet Kaur, Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Muriel S. McKenzie (respondent) appeared and was represented by Kenneth Sheppard, with the law firm Jones Clifford, LLP.

No appearance was made by or on behalf of respondent California Highway Patrol (CHP). Accordingly, the matter proceeded as a default against respondent CHP, pursuant to Government Code section 11520.

Evidence was received, the record was closed, and the matter was submitted for decision on October 9, 2017.
ISSUE

Based upon respondent’s orthopedic (back, neck and arms) condition, is respondent permanently disabled or substantially incapacitated from the performance of her usual and customary duties as a CHP Officer for the CHP?

FACTUAL FINDINGS

Respondent’s Employment History

1. Respondent was employed by the CHP as a CHP Officer at the time she filed her application for industrial disability retirement. By virtue of her employment, respondent is a state safety member of CalPERS subject to Government Code section 21151.

Respondent’s Disability Retirement Application

2. On April 11, 2016, respondent signed an application for service pending industrial disability retirement. She retired for service effective June 3, 2016, and has been receiving her retirement allowance from that date. On May 26, 2016, CalPERS notified respondent that her industrial disability retirement application was cancelled because requested application information was not received by CalPERS. On June 9, 2016, respondent signed and submitted her application for industrial disability retirement. Respondent indicated that her disability occurred in July 1995, and described her specific disability as:

PAIN AND WEAKNESS IN MY BACK[,] NECK AND ARMS FROM DUTY VEST AND GUN BELT.

Respondent wrote that her disability occurred as follows:

WHILE ON DUTY AS A CHP BICYCLE PATROL OFFICER I WAS STRUCK BY A VEHICLE AND THROWN FROM MY BICYCLE.

Respondent wrote that her limitations/preclusions due to her injury were:

UNABLE TO STAND FOR LONG PERIODS – SITTING CAUSES PAIN[,] WEAKNESS IN BOTH HANDS CAUSING GRIP PROBLEMS [.]

Respondent wrote that her injury has affected her ability to perform her job as follows:
On November 8, 2016, Anthony Suine, Chief of the Benefit Services Division for CalPERS, notified respondent that CalPERS reviewed all of the medical evidence submitted. CalPERS's review included the reports prepared by Randall Armstrong, M.D., Charles Sutter, M.D., Scott R. Lipson, M.D., and Robert Henrichsen, M.D. Based upon the evidence in those reports, CalPERS determined that respondent's orthopedic (back, neck and arms) condition was not disabling, and therefore CalPERS found that respondent was not substantially incapacitated from the performance of her duties. Respondent timely appealed the denial.

**Duties of a CHP Officer**

At the time of her application for industrial disability retirement, respondent was employed as a CHP Officer. The California State Personnel Board's Specification (SPB Specification) for Officer, California Highway Patrol, defines the position as follows: "(1) patrol State highways enforcing laws relating to the operation of motor vehicles, or (2) provide law enforcement services to State employees, officials, and the public and provide for the safekeeping of State property, or (3) provide for the protection of the Governor, other constitutional officers, and members of the Legislature, or (4) perform special staff assignments, and to do other related work."

The SPB Specification sets forth typical tasks of CHP Officers. Tasks include: pursuit driving under potentially hazardous circumstances; removing obstacles from the roadway; traffic stops for motor vehicle violations; making a variety of in custody arrests; pursuing and physically subduing combative and belligerent persons, including armed felons; administering field sobriety tests; lifting and carrying accident victims or prisoners in a varying terrain and situations; maintaining firearm proficiency; and controlling crowds during disturbances and other assemblies.

A CalPERS form entitled "Physical Requirements of Position/Occupational Title" sets forth the Physical Requirements Information for a CHP Officer. A CHP Officer occasionally (up to three hours) performs the following activities: sitting, standing, running, walking, crawling, kneeling, climbing, squatting, bending (neck), bending (waist), twisting (neck), twisting (waist), reaching (above shoulder), reaching (below shoulder), pushing and pulling, fine manipulation, power grasping, simple grasping, repetitive use of hands, keyboard use, lifting and carrying from zero to over 100 pounds, walking on uneven ground, working with heavy equipment, exposure to excessive noise, exposure to extreme temperature, humidity and wetness, exposure to dust, gas or chemicals, working at heights, operation of foot controls or repetitive movement, and use of special visual or auditory
protective equipment. A CHP Officer frequently (three to six hours) performs driving activities. The form was signed and dated on June 29, 2016 by respondent's sergeant, but was not signed or dated by respondent.

14 Critical Physical Activities

7. CHP Form 225, entitled “CALIFORNIA HIGHWAY PATROL OFFICER 14 CRITICAL PHYSICAL ACTIVITIES,” sets forth 14 activities and representative job tasks which the CHP Officer is required to perform, and the frequency and duration of those activities. The 14 activities are: (1) Lift/Carry; (2) Push/Pull; (3) Sit; (4) Stand; (5) Squat/Bend/Kneel; (6) Walk; (7) Run; (8) Climb; (9) Jump; (10) Manual Dexterity/Firearms; (11) Drive; (12) Visual Acuity; (13) Color Vision; (14) Hearing.

8. Lifting and Carrying. A CHP Officer is expected to: (1) lift and carry objects weighing 10 to 25 pounds (e.g., gear bag), one to three times a day, for two to five minutes; (2) without assistance, lift and carry objects weighing 30 to 50 pounds (e.g., car tire(s), road debris), one to three times per month, for one minute; (3) with assistance, lift and carry an individual resisting arrest (20 to 35 feet), one to two times per year, for one minute.

9. Pushing and Pulling. A CHP Officer is expected to: (1) pull/drag a non-resistive/incapacitated person (160 to 200 pounds) five to 20 feet at an emergency situation or protest, one to two times per year, for one minute; (2) pull/drag an individual (160 to 200 pounds) resisting arrest five to 20 feet, one to two times per year, for one minute; (3) separate uncooperative persons (160 to 200 pounds) by pushing, pulling, using locks, grips, or holds, and physically restrain or subdue a resistive individual using reasonable force, one to three times per month, for five to 60 seconds; (4) handcuff a suspect, one to three times per month, for one minute; (5) pull/drag heavy objects (e.g., logs) off the roadway (five to 35 feet), four to six times per year, for one minute.

10. Sitting. A CHP Officer is expected to sit in a patrol car for an extended period of time during patrol or surveillance, one to three times per day, for one to two hours.

11. Standing. A CHP Officer is expected to: (1) stand and direct traffic, one to three times per month, for eight to 20 minutes; (2) stand for extended periods at an accident/crime scene, during stakeout, surveillance, and crowd control, to provide security for various events, or to secure the perimeter, one to three times per month, for 30 to 45 minutes.

12. Squatting/Bending/Kneeling. A CHP Officer is expected to: (1) stoop/squat/kneel to look for physical evidence under the seats or dash of a vehicle, in the trunk, and under the hood of a vehicle, to look under a vehicle for evidence, suspects, defects, or violations, or to look under furniture for physical evidence at a crime/accident scene, one to three times per week, for one minute; (2) stoop/squat/bend to set a flare pattern and ignite flares, to set cones at accident/crime scenes, to use a tape measure to measure skid marks, or take measurements at an accident/crime scene, one to three times per month, from
two to five minutes; (3) frisk/pat down individuals for weapons, one to three times per month, for one minute.

13. **Walking.** A CHP Officer is expected to: (1) walk continuously while on foot patrol for special assignments and to conduct searches, one to two times per year, for 30 to 45 minutes; (2) walk around obstacles, over uneven ground, up hills/embankments, in loose dirt, gravel, mud, ice or snow, one to three times per month, for two to five minutes; (3) walk to and from a violator's vehicle, to place flares or cones in traffic, or to keep an eye on a suspect. The distance walked in a day is one-quarter to one mile, one to three times per day, for one to five minutes.

14. **Running.** A CHP Officer is expected to run (five to 100 yards) to get to an emergency or crime scene, to assist other officers, or to pursue a fleeing suspect, one to two times per year, for one minute.

15. **Climbing.** A CHP Officer is expected to: (1) climb over a guardrail or median barrier (two to three feet), one to three times per month, for 10 to 45 seconds; (2) climb over chain link or wooden fences (five to seven feet) and over walls (four to seven feet), four to six times per year, for 10 to 45 seconds, (c) climb steep embankments, hills, or gullies, four to six times per year, for one minute.

16. **Jumping.** A CHP Officer is expected to jump across and/or over obstacles (e.g., guard rail) two to four feet, and down from elevated (four feet) surfaces (e.g., fence), four to six times per year, from 10 to 45 seconds.

17. **Manual Dexterity/Firearms.** A CHP Officer is expected to: (1) fire 50 to 100 rounds with a handgun at a target during practice, firearms qualification, or at a combat style shooting course, four to six times per year, for eight to 20 minutes; (2) fire a shotgun and rifle during practice, firearms qualifications, or on the job, four to six times per year, for eight to 20 minutes; (3) draw and hold a handgun, shotgun, or rifle on a felony suspect until back-up arrives, or to cover an area of responsibility for extended time periods, four to six time per year, for two to five minutes; (4) operate a computer keyboard in an office or in a patrol car to enter/retrieve information and to complete reports or other documentation, one to three times per day, for eight to 20 minutes; (5) operate a radio, cellular phone, sirens and lights, and/or hand spotlight while driving a patrol vehicle, one to two times per hour, for one minute.

18. **Driving.** A CHP Officer is expected to (1) drive on patrol under a variety of conditions and transport prisoners/suspects, one to three times per day, for 30 to 45 minutes; (2) drive a patrol vehicle on open road at high speeds in response to a call or emergency, or in pursuit of fleeing vehicles, under varied conditions, one to three times per week, for eight to 20 minutes; (3) drive a vehicle in a manner to slow down traffic (e.g., weaving back and forth), one to three times per month, for two to five minutes.

*Respondent's Injuries, Treatment and Assistance*
19. In May 1995, respondent was on bicycle patrol in full uniform as a state police officer. She received a call from another officer for backup. She responded to the call and was hit by a van at 30 miles per hour. The impact threw her on the hood of the van. She was then thrown to the roadway and landed on her head. The impact cracked her bicycle helmet. Respondent injured her elbow, hip, knees, ankle, and hands. She was transported by ambulance to UC Davis Medical Center. She went back to work approximately five or six days after the accident. She was placed on light duty at a desk for a month. In July 1995, the state police and CHP merged together as one entity. She became a CHP officer. Respondent obtained physical therapy and chiropractic care on her own for her shoulders and neck. Respondent was subsequently returned to full duty as a CHP bicycle patrol officer. She continued to experience back, neck and arm symptoms from that injury.

20. On October 10, 1996, respondent fell off of her bike, landing on her left side, and striking her left elbow, knee and shoulder. Respondent saw Randall Schaefer, M.D. Dr. Schaefer opined that respondent had multiple contusions, rotator cuff tendinitis, elbow abrasion and "ecchymosis above the hip," all on the left side. Dr. Schaefer explained that the situation should resolve with some time. In November 1996, Dr. Schaefer found that respondent's hip and elbow problems resolved, but her shoulder pain "was annoying." He suggested that respondent's cervical spine was the cause of her shoulder pain. He recommended respondent be evaluated by a neck physician.

21. Respondent was then evaluated by Joe Hartzog, M.D. He opined respondent was able to work and recommended a magnetic resonance imaging (MRI) scan of her neck with some x-rays. He found that when respondent rotated her head to the left, she had pain in the left scapular region.

22. On December 17, 1996, respondent had x-rays taken. M. Raghavan, M.D., found arthritic changes at C4-5 with some mild narrowing in the left-sided foramen. The alignment was intact. There were some mild posterior spurs foraminal spurs "from the uncal joint."

23. On January 2, 1997, respondent had a cervical spine MRI scan. Randy Knutzon, M.D., found the scan unremarkable, and did not see arthritic disease or spondylosis at C4-5. Dr. Hartzog reviewed respondent a week later, and recommended physical therapy. He indicated that respondent was okay to work.

24. Respondent began physical therapy on March 5, 1997. One month later, her physical therapist noted that respondent had sporadic attendance and frequent injuries, but respondent's initial symptoms were prevented from returning. Respondent received mobility strengthening and soft tissue treatment. The burning-like symptoms in respondent's extremities abated.

25. Fourteen months later, respondent saw Richard Baker, M.D., an orthopedic surgeon. Respondent had tenderness in her left side musculature, shoulder and upper extremity joints had a normal range of motion. She had normal strength in her neck, but
experienced tenderness. Her arm strength was normal. There were some mild impingement finds, but did not have atrophy, and her reflexes were intact. There was a gap in respondent’s medical records from 1998 to 2014.

26. On January 29, 2014, respondent took her CHP work truck to the CHP Academy to wash it. She testified at hearing that she stepped on her driver’s seat to remove the antenna. As she did so, she felt a burning sensation run up her back, arms and head. She also felt a stinging sensation on her sides. She was in extreme pain. See saw her family practice doctor, Charles Sutter, M.D, on February 1, 2014. Dr. Sutter put respondent on pain medication, and referred her to physical therapy.

27. On February 18, 2014, respondent had an MRI scan of her cervical spine. Anoop Nundkumar, M.D., interpreted the scan. He identified cervical spondylosis from C2-3 through C5-6. There was moderate foraminal stenosis at C4-5. There was some spur formation at C5-6, and central disc protrusion, but it did not compress or touch the spinal cord. There was also central protrusion at C3-4 and C2-3. Respondent also had a lumbar spine MRI scan performed. Her L1-2 was normal, L2-3 had minimal disc bulge. Respondent’s L3-4 was unremarkable. L4-5 had minimal disc bulge with an annular tear. L5-S1 was unremarkable.

28. On April 16, 2014, respondent initiated physical therapy with Adam Mick, P.T. His therapy plan was joint mobilization and traction of the neck. Therapy continued until May 2014.

29. On May 19, 2014, Randall Armstrong, M.D., evaluated respondent. His review of a lumbar MRI scan showed age-appropriate degenerative changes with good disc space height. A cervical MRI scan shown broad-based disc bulge, but no specific nerve compression. His examination revealed normal reflexes, motor strength, and sensation. He noted tenderness in the cervical spine, but not in the lumbar or thoracic spine. He found no impingement in the shoulders, neck and spine. Dr. Armstrong diagnosed respondent with thoracic sprain, cervical disc degeneration, cervicalgia, and cervical spondylosis. Respondent’s upper extremities were neurologically intact, but she had persistent symptoms.

30. On October 31, 2014, Connor O’Neill, M.D., administered an epidural steroid injection. Dr. O’Neill noted respondent’s bicycle accident “many years ago.” Over the years respondent experienced neck, shoulder and arm pain. Her symptoms “worsened dramatically after the January 29, 2014 incident where she climbed on her driver’s seat while reaching to remove the antenna. She is still working.” Dr. O’Neill reviewed respondent’s cervical MRI scan, and noted “central disc bulging with no neural impringement at C3-4. The other levels are unremarkable.” Dr. O’Neill administered a “cervical inter-laminar epidural steroid injection” and found “excellent circumferential opacification of the epidural space from C3-4 to C6-7.”

31. Dr. O’Neill performed subsequent epidural steroid injections on respondent on January 8, 2015 and June 2, 2016. On January 8, 2015, Dr. O’Neill noted that respondent’s primary complaint was “mid-thoracic pain” and that her “thoracic MRI shows a disc
protrusion at T7-8.” On June 2, 2016, Dr. O’Neill noted a diagnosis of “Thoracic disc herniation” and that respondent experienced “75% pain relief following last thoracic epidural injection.”

32. On April 6, 2016, respondent saw Dr. Sutter. Respondent had a gradual increasing of symptoms of neck and low back pain, and radicular-like symptoms. Respondent’s epidural injections helped her temporarily. Dr. Sutter diagnosed respondent with cervical spondylosis with radiculopathy, hand weakness, arthritic disease in her low back, and thoracic strain. He determined that respondent was not able to perform her duties, which required wearing a gun belt and vest. Respondent could not stand for a prolonged period, and was apparently unable to pull or drag. He determined that respondent was permanently disabled. Three weeks later, Dr. Sutter found that respondent’s symptoms worsened. She had trouble sleeping, and her neck was soft. He opined that respondent had insomnia, menopause, and dehydration. Medications were recommended.

Respondent’s Evidence

33. In support of her application for disability retirement, respondent presented reports prepared by Dr. Sutter, dated April 5, 2016; Imad Rashid, M.D., dated May 17, 2016, February 22, 2017, June 16, 2017, and June 9, 2017; and Dr. O’Neill, M.D., dated October 31, 2014, January 8, 2015 and June 2, 2016. The reports were admitted as administrative hearsay. No medical expert testified on respondent’s behalf at hearing.

DR. SUTTER’S APRIL 5, 2016 REPORT

34. Dr. Sutter is a family practice doctor. Dr. Sutter completed a two-page CalPERS form entitled “Physician’s Report on Disability” which he signed and dated on April 5, 2016. He noted that his first visit with respondent was on January 31, 2014, and that the date of his last examination was on March 30, 2016. He described the origin of respondent’s injury as “hit by van 1995 thrown 17 feet.” He noted that respondent’s chief complaint was “[n]eck pain with intermittent burning pain down both arms into hands” and that respondent’s subjective symptoms were “pain with working new job.” His diagnoses were “Cervical spondylosis with radiculopathy, hand weakness” based on respondent’s cervical spine MRI scan in February 2014, and “Lumbar degenerative disc disease.” Dr. Sutter commented that respondent is unable to perform her job duties “which require a gun belt and vest.”

35. Page 2 of the form, under the heading “Member Incapacity,” states:

To qualify for a disability retirement, the CalPERS member must be substantially incapacitated from the performance of the usual duties of his/her position with the current employer. This “substantial incapacity” must be due to a medical condition of permanent or extended and uncertain duration. Disability is not necessarily an inability to perform fully every function of a
given position. Rather, the courts have concluded that the test is whether the member has a substantial inability to perform the usual and customary duties of the position. Prophylactic restrictions are not a basis for a disability retirement. (Bold in original.)

36. In response to the question whether the member is "currently substantially incapacitated for performance of the usual duties of the position for their current employer," Dr. Sutter checked the box "Yes." He wrote the following: "Unable to stand for any period of time, squat, bend or kneel[ing] (esp wearing vest & equipment)[.] Unable to pull or drag[,] push[]. Unable to perform duties of job which require gun belt and vest[.]" He noted that the incapacity was permanent, that he reviewed the job duty statement/job description, and that he reviewed the "Physical Requirements of Position/Occupational Title" to make his medical opinion.

REPORTS BY IMAD M. RASHID, D.O

37. Dr. Rashid is board certified in Physical Medicine and Rehabilitation. Dr. Rashid performed a workers' compensation evaluation on respondent on May 17, 2016. He examined respondent with respect to her shoulder, neck and back. He noted respondent's chief complaint as "extreme burning pain" between her shoulder blades, "also on the neck, upper and lower back and arms." He performed a review of respondent's medical records, and performed a physical examination. Dr. Rashid did not note any abnormalities or concerns with respondent's cervical spine range of motion, bilateral upper and lower extremities, lumbar spine flexion, muscle strength, reflexes or peripheral pulses.

38. Dr. Rashid diagnosed respondent as follows:


b. MRI evidence of mild cervical and thoracic disc disease without significant stenosis.

c. Bilateral upper extremity radiculitis and paresthesia with reportedly normal electrodiagnostic evaluation.

39. Dr. Rashid concluded that respondent could "return to work with modified duties, not to wear her belt. She should be able to do to her job activities, as I believe that is the major contributor to her symptoms. The patient has two more weeks to retire per her report and hopefully that should not be an issue." Dr. Rashid set forth respondent's treatment plan as including a home exercise program, an epidural steroid injection, and medications. Dr. Rashid did not address CalPERS's standards for industrial disability retirement in his report.
40. Dr. Rashid's February 22, 2017 and June 16, 2017 reports were progress notes containing the same or similar information as May 17, 2016 report. He did not address CalPERS's standards in these progress notes.

**JUNE 9, 2017 REPORT BY KAYVAN HADDADAN, M.D.**

41. Dr. Haddadan is board certified in Physical Medicine and Rehabilitation. He performed a Qualified Medical Examination on June 9, 2017, for purposes of respondent’s workers’ compensation claim. He took a history of respondent’s present injury, a review of systems, a review of her medical records, and performed a physical examination. He did not note whether he reviewed the 14 critical activities of a CHP Officer, or the SPB Specification setting forth the CHP Officer job duties. Upon physical examination, Dr. Haddadan noted tenderness on palpation of the “greater trochanter bursa noted on the left side.” Respondent’s range of motion of her cervical spine was “mildly limited to extension and side bending with pain.” Respondent’s range of motion in her shoulders was noted to be within normal limits. Dr. Haddadan provided the following assessments:

   a. Cervicalgia.
   b. Myofascial pain syndrome.
   c. Thoracic disc herniation.
   d. Lumbar degenerative disc disease.

42. Dr. Haddadan then determined that respondent reached “permanent and stationary status as of 10/22/2016” and engaged in a causation and apportionment discussion related to respondent’s worker’s compensation claim. Dr. Haddadan did not address the CalPERS standard of whether respondent was substantially incapacitated from the performance of her job duties.

**REPORTS BY DR. O’NEILL**

43. Respondent submitted reports dated October 31, 2014, January 8, 2015, and June 2, 2016, by Dr. O’Neill, in support of her industrial disability retirement application. Dr. O’Neill provides “[d]iagnosis and non-surgical treatment of spine disorders, including diagnostic and therapeutic injections and interventional pain management.” Dr. O’Neill’s reports were related to the administration of epidural steroid injections on respondent on the dates of the reports. Dr. O’Neill’s reports did not address the CalPERS standard of whether respondent was substantially incapacitated from the performance of her job duties.

**CalPERS’ Expert, Robert Henrichsen, M.D.**

44. Dr. Henrichsen is a board-certified orthopedic surgeon. On October 11, 2016, Dr. Henrichsen conducted an independent medical examination (IME) of respondent at the request of CalPERS. Dr. Henrichsen reviewed respondent’s medical, occupational and treatment history, performed a physical examination and prepared an IME report dated
October 11, 2016. Dr. Henrichsen’s testimony at hearing was consistent with his IME report, in which he described respondent’s complaints at the time of the IME as follows:

She has back and neck pain, and has a burning sensation in her neck and back. She has difficulty concentrating. She has fears of her back, she wants to protect it ....

An anterior pain drawing demonstrates increased sensitivity in the arms and down the mid forearms on both sides, and also from the cervical spine up to the top of the pinnae on each side. Posteriorly, she has increased sensitivity along the paraspinal region in the cervical spine up again to the pinnae. There is aching in her cervicothoracic junction, midthoracic spine and lumbar spine and then she twinges with motion in her thoracic and lumbar spine.

45. Dr. Henrichsen noted that respondent completed an “ADL sheet,” wherein she described “difficulty standing, sitting, inclined walking, climbing stairs, lifting, grasping, sensation in her hands, riding, driving, flying, and restful sleep. She has back pain in the morning because of lying flat in bed.” On a 10 scale, respondent explained that her worst pain was a 10. “Her pain is aggravated with activity to a 10. She has a 10 pain interfering with sitting 30 minutes, standing 30 minutes, and she limits her activities at 10 level, so she does not get worse. She has 9-level interference with family, interference in work[ing] around home. She has an 8-level pain as an average, her frequency of pain is a 9 level. She has an 8-level pain interfering with daily activities and interfering with concentration.”

46. Dr. Henrichsen further noted that “She has a 7-level interference with writing and typing, getting adequate sleep, participating in social activities, and traveling in a car for 1 hour. She has a 6-level pain with lifting 10 pounds and sexual activity. She has a 5-level difficulty dressing, 5-level difficulty with showering and bathing, and her pain at the time of this evaluation was a 5. She has a 3-level interference with walking 1 block.”

47. Dr. Henrichsen conducted a physical examination of respondent. He noted that respondent walked with a normal heel-to-toe gait. Respondent’s examination was limited to her spine and extremities. Examination of respondent in the prone position showed normal lumbar lordosis: “She has some pain in the left upper buttocks because of the little bit of shooting pain into the thigh, she also has some right thigh pain to palpation.” Dr. Henrichsen further noted, “She does not have thoracic symptoms of tenderness in the midline or paraspinal region nor any significant tenderness in the lumbar paraspinal or central region. There is no spinal evidence of spasm, trigger points, or nodules. Compression of the rib cage produces a little tenderness in the thoracic spine.”

48. While supine, Dr. Henrichsen did not note any abnormalities or concerns. While sitting, Dr. Henrichsen noted normal abduction and adduction hip muscle resistance at the knees, normal hip and knee flexion. “Also, manual muscle evaluation identifies that her
strength is grade 5 on both sides.” Respondent demonstrated normal shoulder range of motion. “With parascapular loading, she has some burning feeling in the cervicothoracic junction. Dr. Henrichsen noted no impingement about respondent’s shoulders. He did not find any abnormalities or have concerns upon examination of respondent’s biceps, forearms, wrists, or hands.

49. Dr. Henrichsen noted that he reviewed a compact disc (CD) of photographic images obtained by Yolanda Clive, a CalPERS investigator with the Disability Validation Team. Investigator Clive did not testify at hearing, but her report and CD images were received in evidence and considered to the extent permitted by Government Code section 11513, subdivision (d).1 Investigator Clive stated in her report that she conducted an internet search of respondent’s Facebook account, which was unlocked. Investigator Clive found various unrestricted postings by respondent, which were photographs of respondent: riding a horse on June 2, 2013 in the Extreme Cowboy Race; respondent mounted and riding on her mule in a parade on April 2, 2014, and in the Winters 75th Annual Youth Day Parade on May 2, 2014; riding in an off-road vehicle on June 21, 2015 in the Nevada desert; and riding in an off-road vehicle on June 19, 2016, where respondent described riding 400 miles off-road. Based upon his review of the pictures he reviewed, Dr. Henrichsen wrote, “I did not see behavior that would warrant narcotic medication.”

50. Dr. Henrichsen’s diagnoses were as follows:

   a. Degenerative disc disease, cervical spine with cervical bulge.

   b. Thoracic disc protrusion without imaging/examination evidence of nerve impingement.

   c. Degenerative disease of lumbar spine.

   d. History of referred lower extremity pain.

   e. Unexplained numbness and tingling of the hands.

51. Dr. Henrichsen noted that he was not provided any of the imaging studies for his review, “and some of the records do not include all the radiologic reports for imaging studies. The EMG/NCV study report is absent.” However, based on the information available, the Dr. Henrichsen opined:

1 Government Code section 11513, subdivision (d), provides, in pertinent part, that “[h]earsay 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.”
Officer McKenzie has degenerative disease in her cervical, thoracic, and lumbar spine. Whether or not any of that is related to her being hit by the bicycle and going up the windshield before 2000 is unknown. The incident of 1/29/2014, where she was on the truck seat reaching to unhook some antennas is trivial, and I cannot see from review of the records that that contributed to any of her current situation.

She has had persistent symptoms, but she was improved mostly by a thoracic epidural injection and to a lesser extent the cervical epidural injection.

Overall, her examination demonstrates she has normal tone and bulk of her musculature, she has no nerve impingement in her spine and to the extremities that can be determined by examination. The actual examination that I accomplished is similar to that of Dr. Armstrong, and the examination support of all of her symptoms is not present.

It appears to me, by review of some of the intake forms that to her understanding of the 10-level pain scale is not the same as healthcare providers' understanding.

Overall, she has some degenerative disease in her spine that so far is not serious, she has symptoms in excess of her examination findings, and she is functioning reasonably well.

52. In response to CalPERS's question whether based on his objective findings, were there specific job duties that Dr. Henrichsen felt that respondent was unable to perform because of a physical or mental condition, and whether there were any critical physical activities that respondent could not perform, Dr. Henrichsen opined that there were no specific job duties that respondent was unable to perform because of a physical condition.

53. In response to CalPERS's question whether respondent is substantially incapacitated from the performance of her duties, Dr. Henrichsen opined that respondent is not substantially incapacitated.

54. In response to CalPERS's question whether respondent cooperated with the examination and put forth her best effort, or whether he felt there was an exaggeration of complaints, Dr. Henrichsen answered that respondent was "cooperative with the evaluation and while she has symptoms in excess of her findings, I did not see that she was intentionally turning up the volume of her symptoms at the time of the evaluation."
55. In response to CalPERS's question whether respondent's condition was caused, aggravated, or accelerated by her employment, Dr. Henrichsen answered, "Taking all the history into consideration and record review, my understanding is that her spine condition is some, but not all, caused and aggravated by her employment. We know that she has not been a sedentary person outside of her occupational duty and we also know that individuals that get a few years on their body, generally will have degenerative changes regardless of their occupational position. Therefore, it is my assessment that some, but not all of her symptoms, would be present if she had not been employed as a California Highway Patrol Officer."

Discussion

56. Respondent primarily relied upon her workers' compensation medical evidence to meet the CalPERS standard for disability that she is substantially incapacitated from her duties as a CHP Officer. She also relied on a two-page CalPERS form completed by Dr. Sutter indicating her diagnoses of cervical spondylosis and degenerative disc disease, and on documentation that she received epidural steroid injections on at least three occasions from Dr. O'Neill. No medical expert testified on respondent's behalf to answer the following CalPERS questions: (1) whether there are any specific job duties that respondent was unable to perform because of her physical condition; (2) whether she is substantially incapacitated from the performance of her duties; (3) if yes, on what date did her disability begin; (4) if incapacitated, is the incapacity permanent or temporary; (5) did she cooperate with the examination and put forth her best effort, or was there an exaggeration of complaints; and (6) was the condition caused, aggravated or accelerated by her employment. Respondent did not meet her burden to establish by competent medical evidence that she is substantially incapacitated from the performance of her job duties.

57. Dr. Henrichsen conducted an IME of respondent, and persuasively concluded that respondent had degenerative disease in her spine. Dr. Henrichsen persuasively concluded that respondent's symptoms were largely subjective, and not supported by the objective findings. Dr. Henrichsen answered CalPERS's questions, and concluded that respondent was not substantially incapacitated from the performance of her duties.

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

2 Although no court construing the Public Employees' Retirement Law (applicable to CalPERS) has ruled on this issue, courts applying the County Employees' Retirement Law have held that the applicant has the burden of proof. (Harmon v. Board of Retirement of San Mateo County (1976) 62 Cal.App.3d 689, 691.) CalPERS may rely on decisions affecting other pension plans when the laws are similar. (Bowman v. Board of Pension Commissioners for the City of Los Angeles (1984) 155 Cal.App.3d 937, 947.) In this case, Government Code
interpreted to mean "the substantial inability of the applicant to perform his usual duties." 
Discomfort, which may make it difficult to perform one's duties, is insufficient to establish permanent incapacity from performance of one's position. (\textit{Smith v. City of Napa} (2004) 120 Cal.App.4th 194, 207, citing \textit{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. (\textit{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 "'[d]isability' 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."


4. \textit{Mansperger, Hosford} and \textit{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 a CHP Officer due to her orthopedic (back, neck and arms) condition. Respondent failed to meet this burden. Her application for industrial disability retirement must, therefore, be denied.

section 31724 (County Employees' Retirement Law) is similar to Government Code section 21151 (California Public Employees' Retirement Law), and the rule concerning the burden of proof is therefore 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 Muriel S. McKenzie is DENIED.

DATED: November 8, 2017

DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings