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:

IRENE E. RAMOS,
Respondent,

and,

CALIFORNIA DEPARTMENT OF
CORRECTIONS AND REHABILITATION,
N.A. CHADERJIAN YOUTH
CORRECTIONAL FACILITY,
Respondent.

Case No. 2017-0023
OAH No. 2017030574

PROPOSED DECISION

This matter was heard before Danette C. Brown, Administrative Law Judge, Office of
Administrative Hearings, State of California, on September 12, 2017, in Sacramento,
California.

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

Carole M. Allen (respondent) appeared and represented herself.

No appearance was made by or on behalf of respondent Department of Corrections
and Rehabilitation, N.A. Chaderjian Youth Correctional Facility (CDCR). Accordingly, the
matter proceeded as a default against respondent CDCR, pursuant to Government Code
section 11520.

Evidence was received, the record was closed, and the matter was submitted for
decision on September 12, 2017.
ISSUE

Based upon respondent’s orthopedic (cervical herniation, cervical radiculopathy, neck strain, thoracic strain, left trapezius strain) condition, is respondent permanently disabled or substantially incapacitated from performing the usual duties of a Casework Specialist for CDCR?

FACTUAL FINDINGS

Duties of a Casework Specialist

1. At the time of her application for industrial disability retirement, respondent was employed as a Casework Specialist for CDCR. CDCR’s Duty Statement for a Casework Specialist sets forth the general description and typical tasks of the job. In general, a Casework Specialist works “under the direct supervision of a Supervising Casework Specialist (on mental health residential units and intake clinic units) or a Treatment Team Supervisor (on Behavior Treatment Program (BTP) units and Sex Behavior Treatment (SBTP) units. The Casework Specialist is responsible for coordinating and implementing an inter-disciplinary program for a caseload of youth in the program units listed above, in a Division of Juvenile Justice Facility.”

2. The typical tasks of the job include:

- 30% Conducting individual assessments of youth to identify risk factors related to re-offending; reviewing case file information; interviewing and directly observing youth; documenting information from assessments, observations, and other staff in writing and/or electronically;

- 25% Ensure youth are appropriately assigned to program activities including groups and individual counseling; conducting weekly individual counseling with assigned youth aimed at collaboratively assisting them in meeting their case plan goals and objectives; communicating weekly with youths’ counselors to ensure they are aware of each youth’s short and long-term goals and objectives; provide coaching in behavior management strategies and reinforcements;

- 20% Chair and conduct regular meetings, case conferences or special staffing to elicit input from other treatment team members to measure a youth’s progress towards program goals and objectives, to discuss and plan continuing program strategies and positive reinforcements, and to re-evaluate the youth’s risk/needs assessment
and case plan as necessary. Complete monthly casework and case report projection reports.

- 15% Receive written reports from counselors including their observations of a youth's behavior indicating the degree of internalization and practice of goal-oriented behaviors, group participation, case notes, disciplinary records, and individual counseling records.

- 10% Attend training, treatment team and other meetings as requested. Adhere to all facility safety and security policies and procedures. Wear required safety equipment. Supervise youth. Respond to emergencies using appropriate levels of intervention and force as needed. Complete all necessary documentation of youth misconduct. Perform other duties as required.

3. The California State Personnel Board's Specification (SPB Specification) for Casework Specialist, Youth Authority, defined the position as providing specialized casework, clinical, diagnostic, and intensive treatment services for wards and residents; maintaining order and supervising the conduct of wards and residents, providing functional casework supervision to the treatment team staff, and protecting and maintaining the safety of persons and property.

4. The SPB Specification sets forth the "Special Physical Characteristics" of the job. The Casework Specialist "must be reasonably expected to have and maintain sufficient strength, agility, and endurance to perform during stressful (physical, mental, and emotional) situations encountered on the job without compromising their health and well-being or that of their fellow employees or that of wards and residents. Assignments during tour of duty may include sole responsibility for the supervision of wards and residents and/or the protection of personal and real property."

5. The SPB Specification also requires the Casework Specialist to comply with peace officer standards. A designated peace officer "must undergo a medical examination to determine that she can perform the essential functions of the job safely and effectively."

**Respondent's Employment History**

6. Respondent was employed by CDCR as a Casework Specialist. She was employed in this capacity 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

7. On December 22, 2015, respondent signed and submitted her application for industrial disability retirement. Respondent indicated that her disability occurred on November 18, 2014, and described her specific disability as:

CERVICAL DISC HERNIATION, CCERVICAL [sic]
RADICULOPATHY NECK MUSCLE [sic] STRAIN,
THORACIC SPINE SPRAIN, LEFT TRAPEZIUS STRAIN.

Respondent wrote that her disability occurred as follows:

PULLED HEAVY MAIN DOOR SHUT WITH MY LEFT ARM BUT DOOR GOT STUCK AND I PULLED DOOR AGAIN AND DEVELOPED PULLING PAIN AT LEFT PARASCAPULAR AREA WITH BURNING SENSATION.

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

NO VIOLENT PHYSICAL CONTACT, RESTRAINING, OR ALTERCATIONS WITH INMATES, LIFT AND CARRY LIMITED TO 20 LBS OR LESS. INTERMITTENT REACHING ABOVE SHOULDHER LEVEL WITH LEFT ARM. THE ABOVE IS PERMANENT ACTIVITY RESTRICTIONS.

Respondent’s worker’s compensation physician was Peter Yip, M.D. Respondent wrote that her injury has affected her ability to perform her job as follows:

12/03/2015, DR. PETER YIP DETERMINED MY WORK RELATED INJURY HAS RESULTED IN PERMANENT DISABILITY WITH A 20% RATING OF TOTAL WHOLE PERSON IMPAIRMENT. INJURY IS PERMANENT AND STATIONARY AND I’M AT MAXIMUM MEDICAL IMPROVEMENT AS OF 12/3/2015.

Respondent also provided the following additional information:

DO [sic] TO MY PERMANENT DISABILITY AND ACTIVITY RESTRICTIONS I CAN NO LONGER PERFORM THE DUTIES OF A CASEWORK SPECIALIST (PEACE OFFICER). [.] EMPLOYER WILL NOT ACCOMMODATE [sic] MY PHYSICAL RESTRICTIONS OR PROVIDE MODIFIED WRK DUTIES.
8. On December 5, 2016, Anthony Suine, Chief of the Benefit Services Division for CalPERS, notified respondent that her application had been denied based upon a finding that her orthopedic (cervical herniation, cervical radiculopathy, neck strain, thoracic strain, left trapezius strain) conditions were not disabling, and therefore CalPERS found that respondent was not substantially incapacitated from the performance of her duties as a Casework Specialist with CDCR DJJ Northern California Youth Correctional Center. Respondent timely appealed from the denial.

Respondent's Injuries, Treatment and Assistance

9. On December 4, 2014, respondent was treated by Johnston Co, M.D. Respondent complained of soreness in her neck and upper back, and had painful sleep with head pain. Respondent had tenderness in her left trapezius area, limited motion of her neck. Dr. Co prescribed Norco, and placed respondent on limited duty. Dr. Co saw respondent again on December 12, 2014, and found respondent in no apparent distress, even though she reported her pain level to be a nine out of 10. Respondent's left shoulder had full range of motion, with tenderness in her upper scapular muscles on the left side. Respondent received a Toradol injection and was placed on continued modified duty.

10. On December 19, 2014, respondent saw Peter Yip, M.D. at Kaiser Permanente. Dr. Yip found that respondent had full range of motion in her neck and lumbar spine. He opined that respondent had a left trapezius and thoracic spine strain. Dr. Yip recommended physical therapy treatments.

11. Respondent received a magnetic resonance image (MRI) scan of her left shoulder in late 2014/early 2015. The MRI showed "AC joint degenerative arthritis, a downsloping acromion, no rotator cuff injury, and no tendinosis," as reported by Jeffrey Miller, M.D.

12. Respondent underwent physical therapy in January 2015. Dr. Yip reassessed respondent on January 26, 2015. Respondent's shoulder range of motion was normal, as were her elbow, hand and forearms. Dr. Yip recommended chiropractic treatments. Respondent's improvement was less than what Dr. Yip expected based upon his assessment. On February 19, 2015, respondent underwent chiropractic treatment from Mark Pedroncelli, D.C. Unlike Dr. Yip, Dr. Pedroncelli found limited motion of the neck, tenderness to T6, normal reflexes, and tenderness in the trapezius and paraspinal musculature. Dr. Pedroncelli opined that respondent had cervical and thoracic strain with myofascial pain syndrome. He recommended modality treatments including traction and spinal manipulation.

13. On February 23, 2015, Dr. Yip completed a physician's report on disability for CalPERS. He explained that respondent had neck and trapezius pain, and had limited motion with tenderness. His understanding was that this caused her substantial incapacity, and that her incapacity was permanent.
14. Dr. Yip reassessed respondent on April 17, 2015. Respondent’s pain level was still an eight to nine out of 10, and she improved from the chiropractic treatments. Dr. Yip reviewed an MRI scan of respondent’s thoracic spine, and saw that respondent was diagnosed with thoracic and left trapezius strain. Respondent wished to continue her chiropractic treatments.

15. On May 26, 2015, respondent received a cervical spine MRI. E. Popsovski, M.D., determined that respondent had multilevel degenerative disease from C3-4 to C6-7, and there was a reduction of the normal cervical lordosis.

16. On June 15, 2015, respondent saw Kern Guppy, M.D., a neurosurgeon. He found numbness and tingling in the back of respondent’s neck, and found respondent’s posture and gait normal. Respondent did not have atrophy. Her reflexes were normal. Dr. Guppy recommended nonsurgical treatments such as traction and epidural injections.

17. On September 8, 2015, Dr. Yip reviewed respondent’s progress. She had limited motion of her neck, tenderness of the left scapular region, and better motion of her left shoulder. Dr. Yip recommended that respondent continue with her physical and chiropractic therapy because of respondent’s significant improvement. Dr. Yip provided modified return to work restrictions for respondent not to climb ladders, limited reaching of the left elbow above the shoulder, and limited pushing, pulling and carrying. In December 2015, Dr. Yip suggested that respondent have a trial period of steroid injections, but respondent declined because she previously had steroid treatment for another issue, and she was not happy with the results.

18. On January 11, 2016, Robert Murphy, M.D., examined respondent. She had pain in her thoracic spine that shot into her pectoral region. Respondent felt that the pain was constant, but Dr. Murphy did not understand why respondent would have shooting pain. Respondent described symptoms into the ulnar aspect of her hand, and headaches present prior to her injury were now more frequent, and in a different location. Dr. Murphy found normal range of motion of respondent’s neck, and both upper extremities, including her left shoulder. Respondent’s reflexes and motor strength were normal. Dr. Murphy concluded that respondent had minimal objective findings on examination and review of her scans, which suggested that respondent was able to return to her regular occupation, which was largely administrative.

19. Jonathan Rutchik, M.D., conducted an electromyogram and nerve conduction study on July 12, 2016. The electrical examination tested both upper extremities. The results were normal.

20. On October 6, 2016, Dr. Yip saw respondent, whose pain continued at the level of eight to nine out of 10. Respondent’s neck motion improved, but respondent had the same tenderness in her left trapezius area. Respondent’s left shoulder range of motion improved. She had no examination findings of nerve impingement.
21. Dr. Henrichsen is a board-certified orthopedic surgeon. On November 3, 2016, Dr. Henrichsen conducted an independent medical examination (IME) of respondent at the request of CalPERS due to her injury on November 18, 2014. Dr. Henrichsen reviewed respondent’s medical, occupational and treatment history, performed a physical examination and prepared an IME report dated November 3, 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 pain in the left side of her neck and behind the left arm down to the elbow region. She has pain in the left trapezius area and had some history of numbness in the left palm in the past. Pain would also go into the direction of the inferior left scapula and from the left trapezius scapula anteriorly into the upper left chest about the level of the rib two or three. Sometimes, she would put a tennis ball over her scapular region and roll on it to reduce symptoms and coughing and sneezing does not reproduce symptoms.

22. Dr. Henrichsen conducted a physical examination of respondent. He noted that respondent walked with a normal heel-to-toe gait. He did not note any concerns with respondent’s cervical range of motion. While prone, respondent’s cervical lordosis was intact. Respondent could turn her head to the right 70 degrees. She did not have spasm trigger points or nodules in her cervical spine, paracervical musculature or upper thoracic spine area. Respondent had multiple areas of tenderness generally in the left trapezius and left supraspinatus area. While sitting, respondent’s parascapular motion was limited on the left with shrugging. Respondent’s shoulder, elbow and wrist ranges of motion were normal.

23. Dr. Henrichsen’s diagnosis and impression were as follows:

   a. Cervical stenosis with multilevel degenerative disc disease.

   b. Symptoms of radicular syndrome, left upper extremity.

   c. No examination findings of radicular syndrome, left upper extremity.

   d. History of thoracic pain with multilevel degenerative disc disease.

   e. Occupational aggravation of her underlying degenerative cervical disc disease.
f. Symptoms in excess of findings.

24. Dr. Henrichsen noted respondent’s medical history as straightforward, and that respondent had a pre-existing degenerative disease in her neck. Respondent had a good trial of nonsurgical treatment. None of respondent’s examining doctors, including Dr. Henrichsen, identified any nerve impingement to examination. Dr. Yip explained that respondent’s chiropractor treatments helped her significantly, but respondent explained that such treatments seemed to aggravate the situation. Dr. Henrichsen found it interesting that respondent “did not have neck symptoms initially,” and her “first episode of reduced neck motion was 5/2015, which is six months plus after the incident at work.” Dr. Henrichsen noted that respondent’s “nonsurgical treatment did not include epidural injections, which would have been an appropriate option.”

25. Dr. Henrichsen also noted that during the examination, respondent would report her pain level as an eight to nine out of 10, and “at a variety of visits, the physician would find her in no acute distress, so that her understanding of the numerical pain level was different than that of healthcare personnel.” Dr. Henrichsen concluded that respondent had degenerative disease in her neck, and her symptoms were “not supportive of findings of some nerve pain and/or referred pain in her left arm.” There was no evidence of nerve impingement syndrome.

26. Dr. Henrichsen did not find any specific job duties that respondent could not perform, based upon objective examination due to a physical problem. He concluded that respondent not was substantially incapacitated for the performance of her duties. Dr. Henrichsen opined that respondent’s duties were “largely administrative, and the quantitative check sheet regarding occupational duties indicates lifting up to 25 pounds, which is within her physical ability.”

27. In response to CalPERS’ question whether respondent’s condition was caused, aggravated or accelerated by her employment, Dr. Henrichsen opined that it was “more likely probable that she would have these symptoms if she had not had this occupation, because cervical degenerative disease is indeed a degenerative issue, it gradually continues and sooner or later individuals will have an onset of symptoms. We know that her electrical study was normal, and so she does not have any long-standing nerve impingement.”

Respondent’s Testimony

28. Respondent explained how her injury occurred. She stated that the main doors to the living unit, or block, weighed 550 pounds each. The doors were not electric, and one of the doors needed to be fixed. Respondent was walking through a couple of gates, into the main gate. A scuffle occurred behind her, and she was startled. Respondent pulled the door closed, and while doing so, the door jerked her back. She experienced a burning sensation which never went away.
29. Respondent went back to work for two months on modified work duty. Six months later, she received a phone call from the superintendent, who asked respondent whether she wanted to come back to work on modified duty for 60 days. During that time, respondent was not to have any contact with wards or inmates. Respondent went back to work and made a "good faith effort" to carry out her work duties. However, respondent's worker's compensation case settled, and her last day of work was on July 11, 2015.

30. Respondent has been seen by two orthopedic surgeons. She has been told that she is not going to get better, and is "really looking at the surgery." She will find out shortly when her surgery will be scheduled. Respondent did not indicate what type of surgery she will have. Respondent admitted that "it is premature to say I am incapacitated or not." She feels that further examination is needed.

31. Respondent asserted that as a peace officer, her duty to the prison system is to respond to emergencies. She is a first responder. She believes that her job description is misleading. Respondent does not feel that she can work at full capacity when I am scheduled for surgery. She carries a duty belt and a staff vest as part of her uniform. She feels the duty belt and vest are a lot of weight for her shoulders and back.

Discussion

32. Respondent relied upon her worker's compensation medical evidence to establish the CalPERS standard for disability that she is substantially incapacitated from her duties as a Casework Specialist. 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.

33. Dr. Henrichsen conducted an IME of respondent, and concluded that respondent had degenerative disc disease. He did not find any radicular syndrome in respondent's left upper extremity, where she reportedly experienced pain at a level eight to nine out of 10. 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 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”].)

   Findings issued for the purposes of worker's compensation are not evidence that respondent's injuries are substantially incapacitating for the purposes of disability retirement. (Smith v. City of Napa, (2004) 120 Cal.App.4th 194, 207; English v. Board of Administration of

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1 Although no court construing CalPERS law 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 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.
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 a Casework Specialist due to her orthopedic (cervical herniation, cervical radiculopathy, neck strain, thoracic strain, left trapezius strain) condition. Respondent failed to meet this burden. Her application for industrial disability retirement must, therefore, be denied.

ORDER

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

DATED: October 11, 2017

DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings