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: SHAUNA LEA BUTLER, Respondent, and DEPARTMENT OF CORRECTIONS MULE CREEK STATE PRISON, Respondent.	Case No. 2016-1302 OAH No. 2017020330

PROPOSED DECISION

Administrative Law Judge Ed Washington, Office of Administrative Hearings, State of California, heard this matter on July 14, October 2, and November 3, 2017, in Sacramento, California.

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

Shauna Lea Butler (respondent) represented herself.

The Department of Corrections Mule Creek State Prison (CDCR) made no appearance. CalPERS properly served CDCR with the Notice of Hearing. This matter proceeded as a default against CDCR pursuant to Government Code section 11520.

Evidence was received at hearing. The parties agreed to simultaneously submit written closing briefs. On November 17, 2017, both respondent and CalPERS submitted closing briefs, which were marked as Exhibit J and Exhibit 27, respectively. The record was closed and this matter was submitted for decision on November 17, 2017.

ISSUE

Is respondent permanently and substantially incapacitated from performing her usual duties as a Pharmacy Technician for CDCR, on the basis of orthopedic (back and neck), psychological (depression), or rheumatologic (psoriatic arthritis) conditions?

FACTUAL FINDINGS

Respondent's Employment History

1. Respondent is 48 years old. She was employed as a Pharmacy Technician by CDCR. By virtue of her employment, respondent is a state miscellaneous member of CalPERS subject to Government Code section 21151.

Respondent's Disability Retirement Application

2. On May 26, 2016, respondent filed a Disability Retirement Election Application (Application) with CalPERS. On the Application, respondent checked the box which indicated "Industrial Disability Retirement" as the Application Type. She specified her disability as "chronic lower-upper back, migraine headaches, neck pain, sciatic nerve pain both [left and right], depression, anxiety, 3 surgeries, [left and right] knees, and [left] foot." She specified that her disability occurred on April 15, 2011, when "[she] fell on [a] concrete floor while going to sit on a rolling chair, hit the floor hard." She described her limitations and preclusions as follows: "Cannot stand-sit, walk, stoop, bend for very long – in [constant] pain and cannot focus." In the Application, respondent stated that her disability affected her ability to perform her job duties as follows:

> I can no longer do my job. I tried many times to go back to work but it got so bad I could not even meet [my doctors] limitations so I kept trying for over 2 years . . . I tried so hard and was able to push through but it got to the point where I no longer could. I am in constant body pain.

3. By letter dated February 8, 2016, CalPERS notified respondent that, after reviewing the medical evidence, it determined that her "psychological and orthopedic (neck , lower back) [conditions] are not disabling." Consequently, CalPERS denied the Application. Respondent appealed from CalPERS' denial. On April 3, 2017, complainant, Anthony Suine, Chief, CalPERS Benefit Services Division, made and filed the Amended Statement of Issues in his official capacity. On May 5, 2017, paragraph VIII of the Amended Statement of Issues was amended, on respondent's motion, to include "'Rheumatologic condition (Psoriatic Arthritis)' as one of respondent's three medical conditions that will be addressed at hearing."

Duties of a Pharmacy Technician

4. According to the Mule Creek State Prison Job Description, a Pharmacy Technician assists in the operation of the facility pharmacy; maintains drug and supply inventory and inventory records; orders supplies to maintain level of stock; checks goods received against purchase orders, invoices, and requisitions; segregates, labels, and stores pharmaceutical supplies; reviews pharmacy stock for expired drugs; picks up and delivers drugs; cleans equipment, shelves, and work areas; operates packaging machinery for unit dose or prepackaged dispensing system; types labels for medications and delivers to pharmacist for affixing; retrieves designated drug containers; maintains patient medication profiles and records of prepackaged drugs; prepares unit dose cassettes for review by pharmacist; fills medication drawers with prescribed doses; aids pharmacist in preparation of prescriptions; and does other services and technical pharmacy work which does not require licensure.

5. The Physical Demands portion of the job description specifies that a Pharmacy Technician must constantly (involving two-thirds or more of the workday) perform hand and wrists movements, such as handling paperwork, using a phone and computer, writing, handling supplies and instruments, and preparing and dispensing medication. A Pharmacy Technician must frequently (involving one-third to two-thirds of the workday) lift pharmaceuticals and pharmacy equipment, stand, walk, sit, use fine finger dexterity, and frequently use hand and wrist movements to type labels and fill prescriptions. A Pharmacy Technician will occasionally (involving one-third or less of the workday) lift up to 50 pounds of supplies, carry supplies a distance of approximately 20 feet, bend, stoop, reach up or overhead, climb, balance, kneel or crouch, and push or pull.

6. On June 4, 2015, a CDCR representative and respondent signed a document titled "Physical Requirements of Position/Occupational Title" and submitted it to CalPERS. The document described the type and frequency of physical activities that must be performed by a Pharmacy Technician. This included constantly (over six hours) engaging in simple grasping and repetitive hand use; frequent (from three to six hours) sitting, standing, walking, bending, twisting, fine manipulation, mouse use, keyboard use, and driving; and occasional (up to 3 hours) kneeling, climbing, squatting, reaching, pushing and pulling, power grasping, and lifting or carrying up to 50 pounds.

Respondent's Evidence

RESPONDENT'S TESTIMONY

7. Respondent began working at Mule Creek State Prison in November 2001. She last worked there in October 2013. In 2011, respondent injured herself while at working. She fell out of an office chair onto the concrete floor. She filed a workers' compensation claim that was accepted based on "back and neck issues." According to respondent, the fall resulted in her having "compression fractures." Respondent's back and neck issues were initially treated by Douglas Merrill, M.D., who referred respondent to physical therapy and

recommended she take ibuprofen and tramadol for pain. Respondent also saw Michael Yang, M.D., who continues to treat respondent's pain. In addition to physical therapy, Dr. Yang treated respondent with acupuncture, anti-inflammatory medication, and lidocaine patches.

In 2012, respondent fell at work while walking down steps. She missed one of the steps while accessing them and fell to the ground. According to respondent, the fall resulted in a meniscus tear that was surgically repaired in November 2012. Respondent's back and neck pain became progressively worse. In or around 2015, respondent was referred to Anand Lal, M.D., a rheumatologist, for assessment. According to respondent, Dr. Lal diagnosed respondent with psoriatic arthritis.

8. According to respondent, in 2013, she had foot reconstruction surgery due to "tissue degeneration." In May 2015, she had right knee surgery "to remove 75 percent of [her] meniscus," due to continued degeneration. She testified that in the same year, diagnostic imaging revealed that she had degenerative joint disease, sciatica, disc protrusions at L4-L7, spinal stenosis at L5-L6, and spondylosis at L4-L5.

9. Respondent's injuries limit her ability to engage in daily activities, such as showering and dressing, and she "crawls around" to complete many activities throughout each day. She uses crutches or a "knee scooter" daily for mobility. Respondent testified that she can stand for a maximum of approximately five minutes and can only walk for approximately one minute before her legs will "give out" and cause her to collapse. She stated that her knees do no support her enough to allow her to climb a ladder. Respondent can sit for extended periods if she is able to change positions when needed. She can also bend periodically, but frequent bending causes her back to "go out."

10. Respondent also suffers from depression and anxiety. According to respondent, Robert E. Schneider, M.D., diagnosed her with severe depression in 2015. She has suffered from a variety of depression-related symptoms since 2014, including, being very emotional, crying easily, being easily overwhelmed, and being angry. Her depression affects her ability to perform her job because she cannot focus and is "scatter-brained." Respondent's anxiety will sometimes manifest as panic attacks and affect her ability to perform her job, because she feels as if she cannot breathe.

11. Respondent also suffers from fibromyalgia. According to respondent, Dr. Lal diagnosed her with fibromyalgia in 2015. She suffered from the symptoms of fibromyalgia for approximately three years prior to being diagnosed. It causes her to feel "constant chronic pain in her neck, back, wrists, and legs." She experiences "severe muscle pain that is different than the bone pain" and feels "like having the flu." The symptoms of respondent's fibromyalgia interfere with her ability to perform her job because they create constant pain that is sometimes immobilizing.

12. Respondent also suffers from psoriatic arthritis. She testified that Dr. Lal diagnosed her with this condition in late 2015, because her ankles, fingers, and knees were

aching, swollen, and stiff. At times, the swelling is so very severe that she cannot walk or wash dishes. She treats her psoriatic arthritis with the anti-inflammatory methotrexate.

Testimony of John Kish

13. John Kish (John) is respondent's son. He does not currently live with respondent, but has witnessed respondent's deteriorating health over approximately the last seven years. He has noticed "dramatic changes" in her abilities during that time. When respondent initially had knee surgery, he believed she would fully recover and return to her typical day-to-day activities. However, respondent never recovered and her health deteriorated.

14. John has witnessed his mother's depression and described her as being "broken down and a shell of what she used to be." His mother previously maintained a very clean and organized household, which she was proud of. Now, due to her deteriorated condition, respondent cannot sweep and mop the floors without experiencing fatigue and significant pain. He has witnessed his mother being upset that she is unable to clean their home. His mother is forced to make "energy choices," to determine what she can accomplish around the house out of the several chores she would like to complete. Respondent "hits a wall that she cannot push through [because] she is severely crippled." After cleaning around the house, respondent will be "couch bound" for a couple of days thereafter.

Testimony of Cody Kish

15. Cody Kish (Cody) is also respondent's son. He currently lives with her. Cody recalled that his mother fell at work in or around 2012, and has seen her condition worsen ever since. Respondent would try to "push through" the apparent pain and fatigue, but it has become more and more difficult for her to do this. When at home, respondent usually uses a scooter to ambulate. When they are away from home, respondent uses crutches for support. At times, when respondent's symptoms are improved, "she is really proud of being able to just walk around."

Medical Reports and Documents

16. To support her application, respondent submitted two reports from Dr. Schneider, two reports from Joseph R. Ambrose, D.C., and one report from Debra Templeton, M.D. CalPERS submitted reports from Robert K. Henrichsen, M.D., Michael S. Barnett, M.D., Douglas M. Haselwood, M.D., and Alberto Lopez, M.D. Respondent also submitted copies of several doctor's notes and x-rays related to her evaluation and treatment by her healthcare providers. The reports of Drs. Schneider, Ambrose, Templeton, and Barnett were admitted as administrative hearsay and have been considered to the extent permitted under Government Code section 11513, subdivision (d).[1] The reports of Drs.

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

Henrichsen, Haselwood, and Lopez were admitted as direct evidence, given their testimony at hearing, discussed below.

EVALUATION REPORTS FROM ROBERT E. SCHNEIDER, PH.D.

17. Dr. Schneider is a clinical psychologist. On January 28, 2014, in his capacity as a Qualified Medical Evaluator (QME), he evaluated respondent to assist with determinations related to respondent's workers' compensation claims. Dr. Schneider prepared a 16-page QME report reflecting his findings and conclusions. As a result of this evaluation, Dr. Schneider diagnosed respondent as follows:

Axis I: 309.28 Adjustment Disorder, with Mixed Emotional Features: depression and anxiety.

307.89 Pain Disorder, associated with psychological and general medical factors.

780.52 Insomnia Type Sleep Disorder.

Axis II: No Diagnosis.

Axis III: S/P left arthroscopy meniscectomy, chronic back and neck pain.

Axis IV: Loss of her husband in 2004, inability to return to usual and customary employment.

Axis V: Current GAF: [see report]

18. Regarding respondent's ability to work, Dr. Schneider noted in his report that respondent had not received adequate psychological treatment, and for that reason, had not reached maximum medical improvement. He added that his testing suggested that respondent did not have the sustained concentration to perform her job, and determined that respondent had been temporarily totally disabled "since she was taken off work in September 2013."

19. On April 21, 2015, Dr. Schneider performed another QME of respondent. He completed the evaluation and prepared a 15-page QME report. As a result of the April 2015 evaluation, Dr. Schneider diagnosed respondent as follows:

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

Axis I: 309.28 Adjustment Disorder, with Mixed Emotional Features: depression and anxiety.

307.89 Pain Disorder, associated with psychological and general medical factors.

300.1 Anxiety Disorder, NOS.

Axis II: No Diagnosis.

Axis III: chronic back pain, knee pain, upcoming surgery for the right knee.

Axis IV: inability to return to usual and customary employment. Impending retirement, death of her husband in 2004.

Axis V: Current GAF: [see report]

20. Regarding respondent's work status, Dr. Schneider opined that as of the April 2015 QME, it did not appear that psychiatric symptoms would interfere with respondent's ability to perform her former job duties "if she were physically able to do so."

EVALUATION REPORTS FROM JOSEPH R. AMBROSE, D.C.

21. Dr. Ambrose is a chiropractor. On July 10, 2014, in his capacity as a QME, he evaluated respondent to assist with determinations necessary for her workers' compensation claims. He interviewed respondent, reviewed her medical records, discussed her present complaints and conducted a physical examination. As a result of the this evaluation, Dr. Ambrose's diagnoses and objective findings were as follows:

DIAGNOSIS

1. Cervical myoligamentous strain.
2. Probable cervical facet syndrome.
3. Cervical disc protrusion, multilevel.
4. Thoracic myoligamentous sprain strain.
5. Probable thoracic facet syndrome.
6. Lumbar myoligamentous sprain strain.
7. Lumbar disc protrusion.
8. Probable lumbar facet syndrome.
9. Sciatic radiculitis.
10. Cervicogenic cephalgia.

Objective findings -

1. Decreased range of motion of the cervical spine, in all planes.
2. Positive provocative maneuvers to the cervical spine.
3. Decreased range of motion of the lumbar spine, and all planes.

4. Positive provocative maneuvers to the lumbar spine.
5. Cervical, thoracic and lumbar paraspinal muscle guarding and tenderness bilaterally.
6. Hypoesthesia of the right L5 and S1 dermatome.

(Bolding and capitalization in original.)

22. Based on this evaluation, Dr. Ambrose determined that respondent should be temporarily precluded from any repetitive bending, repetitive light lifting or any heavy lifting, given her subjective complaints and objective finding findings upon examination. On July 23, 2015, Dr. Ambrose again evaluated respondent as a QME and prepared a 13-page report reflecting his findings and conclusions. The diagnosis and objective findings contained in the subsequent QME report were virtually identical to those specified in the previous report from Dr. Ambrose. However, in the "Work Preclusions" section of the report, Dr. Ambrose opined that respondent "should be permanently precluded from any repetitive bending, repetitive light lifting or any heavy lifting."

EVALUATION REPORT FROM DEBRA TEMPLETON, M.D.

23. Dr. Templeton is an orthopedic surgeon. On August 10, 2017, she performed a fitness for duty evaluation on respondent. She interviewed respondent, reviewed respondent's medical records, essential job functions, and job description. Dr. Templeton then completed a physical examination, and prepared an eight-page report. She had no imaging studies or diagnostic studies available for review at the time of her examination.

24. In the "Impression" section of her report, Dr. Templeton specified that respondent has Chronic Pain Syndrome, bilateral knee arthritis, right carpometacarpal arthritis, left distal radius malunion, and pustular psoriasis. In the "Comment" section of her report, Dr. Templeton specified that respondent's case is challenging because she suffers from chronic pain that limits her ability to maintain her household and to work, but the source of respondent's chronic pain complaints was not clear. Dr. Templeton opined that respondent was not fit for duty and was unable to of perform the essential functions of her position due to chronic pain, deconditioning and narcotic dependence which causes psychomotor impairment. Dr. Templeton summarized her conclusions as follows:

> Regardless of the ideology of her pain, [respondent] has chronic pain and her symptoms significantly interfere with her activities of daily living, and work obligations. Her pain has resulted in nonrestorative sleep, fatigue, and disability out of proportion with her impairment, all which further contribute to the cycle of chronic pain. It is my opinion that in [respondent's] present condition, she is not able to perform the necessary job duties required of her, as outlined in the provided job description. I do not believe there any accommodations that would make it permissible for her to return to work, even on a part-time basis.

[Respondent] is dependent on narcotics. Side effects of narcotics are not conducive to a safe work environment. She is physically deconditioned as a result of her chronic pain. She does not have the endurance required to stand for more than 30 minutes at a time, or to sit for longer than an hour. If [respondent] desires to be employable in the future, she will need to take steps to assist in her recovery such as smoking cessation, weight control, discontinuing chronic narcotic use, and physical and psychological rehabilitation. It is my sincere hope for her generalized well-being that she continues to make efforts in these areas.

EVALUATION REPORT FROM MICHAEL BARNETT, M.D.

25. Michael Barnett, M.D., is a psychiatrist. On September 11, 2015, Dr. Barnett performed an Independent Medical Examination (IME) of respondent to assist with determining whether she had a psychiatric condition that would prevent her from substantially performing her job. Dr. Barnett reviewed treatment records, and interviewed and examined respondent. He also reviewed the Application and the requirements of respondent's job. On September 15, 2015, he generated a report reflecting his findings and conclusions.

26. During the interview, respondent's primary complaint was that she was "bummed out." A review of respondent's history revealed that in 2004, she spent approximately a week in a psychiatric hospital and was treated for depression after her husband's death. Several members of her family have abused alcohol, including both her parents and several of her siblings.

27. After completing the September 5, 2015 psychiatric evaluation, Dr. Barnett reached the following DSM-IV diagnoses:

Axis I:	309.28, Adjustment Disorder with mixed Depression and Anxiety. Rule out 309.81, physical abuse as a child and in her first marriage. 296.26, Major Depressive Disorder, single episode, in full remission.
Axis II:	None.
Axis III:	General Medical Conditions: Allergies, migraine headaches, osteoarthritis, fibromyalgia, psoriatic arthritis.
Axis IV:	Psychosocial Stressors: Physical problems.
Axis V:	Global Assessment of Functioning: 50.

28. In his report, Dr. Barnett concluded that respondent had "no significant psychiatric symptoms that would interfere with the performance of her job." He added that he believed respondent had "significant physical problems," that were beyond the scope of his examination. He opined that there were no specific job duties that respondent could not perform due to a psychiatric condition, and therefore concluded that respondent was not substantially incapacitated from the performance of her usual job duties. Dr. Barnett reiterated these same findings and conclusion in a Supplemental Reports prepared for CalPERS on January 11, 2016, and July 8, 2016.

Expert Opinions

29. CalPERS called Drs. Henrichsen, Haselwood, and Lopez, as its expert witnesses. Respondent did not call any expert to testify on her behalf.

ROBERT K. HENRICHSEN, M.D.

30. Dr. Henrichsen is a board-certified orthopedic surgeon and a certified Fellow of the American Academy of Orthopaedic Surgeons. He obtained his medical degree from Loma Linda University in 1967. He was in private practice with Auburn Orthopaedic Medical Group from 1973 until 2011. His practice currently involves performing IMEs and QMEs for a variety of entities. On October 6, 2015, he performed an IME on respondent "to determine her occupational work capacity based upon her knees." His evaluation included interviewing respondent, conducting a physical examination, and reviewing her job functions and medical records. Dr. Henrichsen detailed his October 2015 evaluation, along with his findings and conclusions, in a 24-page IME report.

31. During the interview, respondent reported left and right knee pain, lower back pain more on the right side than the left that radiated into the hips. She reported right leg sciatica-like symptoms and left foot pain when bearing weight. For pain, respondent took Percocet and Vicodin twice a day, and also used lidocaine patches.

32. Dr. Henrichsen examined respondent's lumbar spine and lower extremities. Respondent was able to stand on her heels and toes. Her hip muscle weakness test was negative. A femoral nerve traction test revealed no signs of femoral nerve tension. She was able to stand up straight and had normal lumbar lordosis. Upon prone examination, respondent had pain from T12 to L5, with no apparent trigger points, tenderness, or spasm. There was no pain or tenderness in her hip area or over the buttocks at the sciatic nerve. Upon supine examination, right ankle extension produced low back pain, but left ankle extension did not produce pain. Measurements of the thighs, knees, and legs were nearly identical. There was no evidence of mechanical meniscal instability, but there was tenderness near the middle of both knees. A sitting examination revealed tenderness at the back of respondent's right knee. There was no peroneal nerve irritation and respondent had normal strength in both lower extremities. Respondent could extend both knees to full extension without radicular symptoms or findings.

33. After conducting a physical examination and reviewing the available records, Dr. Henrichsen reached the following diagnostic impressions:

1. Chronic low back pain with history of lumbar contusion.
2. History of degenerative arthritis, right and left knee.
3. History of bunion surgery, left foot, and mid foot fusion.
4. Pain symptoms in excess of objective abnormal findings.
5. Lumbar spine diagnosed degenerative disc disease and degenerative arthritis.

34. Dr. Henrichsen determined that respondent's reported knee symptoms were not supported by objective findings upon examination and were not supported by the "inadequate" medical records. He also determined that there were no specific job duties that respondent was unable to perform. For these reasons, Dr. Henrichsen concluded that respondent was not substantially incapacitated from the performance of her usual job duties. He also included the following comments in his October 2015 report regarding respondent's capacity to perform her job:

> There is a large inadequacy of the important medical records. There are lots of records that discuss lots of symptoms, treatment of symptoms, and treatment of chronic degenerative disease of the spine without very good results, which is common. There is significant discussion about radiculopathy and sciatica and all, but no examination ever demonstrated evidence of sciatic nerve irritation. There was an EMG with some abnormal changes, but the EMG changes do not fit the MRI scans of the lumbar spine, and they do not fit the examinations.
>
> As I look at the situation. Overall, there is a large subjective overlay, and many but not all of the decisions made by previous healthcare providers, are based upon symptoms, pain, tenderness, and abnormal imaging findings.
>
> While I recognize that there are different opinions by different groups of physicians, my approach for her to continue taking Vicodin and Percocet on a regular basis finds that the indications for [their use] is not present.
>
> There is a serious inadequacy of some of the medical records. There is no history that I could find of standing x-rays of the knees, and the general description of the knee issues is that there was some arthritis at the time of the left knee arthroscopy. There are no records or history of x-rays regarding the left foot, and so, in retrospect, I cannot determine how much mechanical

damage or pathology was present in either knee or the left foot. What I can determine, in the low back is that she has some chronic degenerative disease of a mild amount. She has no nerve impingement. Her spine is stable, and she has lots of pain, with treatments of injections and other nonsurgical approaches which have not been very successful, as I look at the medical records which are submitted.

Overall, her hard-core objective findings are that she is functioning normally on an everyday basis. She has lots of symptoms, but there is no evidence of nerve impingement from any part of her spine; her lumbar spine is stable. Her MRI scans demonstrate some mild degenerative disease, but no evidence of neurological compression. Her lower extremity joints have a reasonable but not perfect range of motion, and there are no x-rays to support symptoms in her feet or knees.

The incomplete records submitted do not support substantial knee occupational and capacity.

35. On December 8, 2015, Dr. Henrichsen performed a second IME on respondent "to address allegations of chronic lower back pain and neck pain." Again, his evaluation included interviewing respondent, conducting a physical examination, and reviewing her job functions and medical records. Dr. Henrichsen also prepared a 22-page report detailing his evaluation and reflecting his findings and conclusions.

36. During the December 2015 evaluation, respondent reported pain in the back of the neck, thoracic spine, lumbar spine and "sharp twinges" with motion just below her hips and knees. She reported difficulty bathing, dressing, writing, sitting, standing, walking, climbing stairs, lifting and grasping, driving, writing, and having restless sleep. She reported her pain level as being at a level seven on a 0 to 10 pain scale (10 being the worst), which elevates to a 10 with activity. She reported her symptoms as being constant. She reported level six pain when bathing, and pain at a level seven when writing, typing, walking approximately one block, when lifting 10 pounds, sitting for 30 minutes, and when traveling in a vehicle for one hour. She experiences pain at a level eight "when with family and doing work around the home." She reported pain at level 10 when standing for 30 minutes and when engaging in daily activities. She reported having anxiety, depression and irritability at a level seven on a 0 to 10 scale.

37. After completing the December 8, 2015 physical examination and reviewing the available records, Dr. Henrichsen reached the following diagnostic impressions:

1. History of lumbar contusion with chronic low back pain.
2. No lumbar or cervical radiculopathy.
3. History of degenerative arthritis, right and left knee.

4. History of bunion surgery, left foot, with gastrocnemius fascial release.
5. Symptoms in excess of objective findings.
6. Degenerative disc disease and degenerative arthritis, lumbar spine.
7. Degenerative disc disease and degenerative arthritis, cervical spine.
8. Unfavorable power-to-weight ratio.
9. Chronic narcotic medication use.

38. Based on the his evaluation and the available records, Dr. Henrichsen determined that respondent's lower back and neck pain, or any other orthopedic condition he observed, did not preclude her from performing any of her specific job duties. The objective findings did not support respondent's claimed incapacity. Dr. Henrichsen included the following comments in his December 2015 report regarding respondent's reported incapacity:

> [Respondent] has a significant disconnect between her symptoms and findings, and it is suggestive to me that she has a somatoform pain disorder, and that psychological issues are manifested as physical symptoms. In general, when one looks at the variety of evaluations by variety of different healthcare providers, it can be seen that she does not have specific focal muscle weakness. She has a lot of symptoms. She has not [had] very good response to treatment, and that some of the medical providers have produced judgments based upon her symptoms, without supporting examination findings.
>
> She has some arthritic degenerative disease in her neck and her low back. She has some early arthritic changes in her knees, but otherwise, she is functioning physically well in her fifth decade of life. Unfortunately, her unfavorable power to weight ratio contributes to her pain symptom complex.
>
> As indicated my previous summary. Her spine is stable in the cervical and lumbar spine. She has no nerve impingement. She has lots of pain, and the treatments of her injections have not been very successful. Again, when one steps back and looks at her hard-core objective findings, it can be seen that she is functioning normally on an everyday basis. Her lower extremities have adequate range of motion, and again, x-rays supporting her knee and feet symptoms are absent.

39. CalPERS provided Dr. Henrichsen with additional records to review regarding respondent medical condition and symptoms, and asked that Dr. Henrichsen provide a

supplemental report. Dr. Henrichsen reviewed those records and, on July 5, 2016, prepared a 17-page supplemental report. After reviewing the additional records provided, Dr. Henrichsen's opinions were unchanged.

40. During his testimony at hearing Dr. Henrichsen reiterated and supported each of the conclusions specified in his IME reports. He acknowledged that the limited medical records provided was concerning, but ultimately reached his conclusions based on all the information available to him during the evaluations. He emphasized that there must be a reasonable correlation between respondent's symptoms and the medical findings. Dr. Henrichsen acknowledged that respondent had some difficulty squatting and had some spinal abnormalities typically associated with degenerative disc disease that many people experience over time. However, in his opinion, those conditions were not labor disabling as they do not prohibit respondent from substantially performing her job duties.

DOUGLAS M. HASELWOOD, M.D.

41. Douglas M. Haselwood, M.D., is a rheumatologist. He received his medical degree from the University of Rochester School of Medicine in 1972. He holds certification with the American Board of Internal Medicine, and the American Board of Internal Medicine, Rheumatology. On September 2, 2016, Dr. Haselwood performed an IME on respondent "focused on the current nature and severity of [respondent's] rheumatologically-related musculoskeletal afflictions." Dr. Haselwood interviewed respondent, reviewed respondent's medical records, performed a physical examination on respondent, and then prepared a 14-page IME report reflecting his findings and conclusions.

42. During the interview, respondent presented Dr. Haselwood with a "complex, convoluted and forgetful medical history." She complained of constant widespread musculoskeletal soft tissue and joint pain that fluctuated from minor to severe. Respondent identified the sources of her musculoskeletal pain. She described a fall in 2011, that caused "compression fractures" in her lumbosacral region that resulted in ongoing lower back pain. She had a second fall in 2012, that caused a meniscus tear "that did not fully resolve after surgery," and causes her left knee pain. She also reported that in 2013, she began to experience increasing left foot pain with weight bearing that resulted in "foot collapse." Respondent also told Dr. Haselwood that her lower back, left knee, and left foot problems were all exacerbated by "a right knee condition" she developed in 2015.

43. Additionally, respondent reported that the majority of her musculoskeletal pain and dysfunction stemmed from her fibromyalgia and psoriatic arthritis. However, respondent could not identify "the chronology and evolution" of those afflictions. After completing his evaluation Haselwood reached the following diagnostic impressions:

1. Rheumatologically relevant diagnoses to include:

    a. Chronic, poorly defined widespread musculoskeletal soft tissue discomfort and dysfunction syndrome with

somewhat inconsistent and tangential historical reference to the syndrome of fibromyalgia.
b. Credible, albeit rather abbreviated historical and physical implications for psoriatic arthritis currently under immunomodulating treatment.

2. Chronic, complex and somewhat poorly defined generalized narcotic dependent musculoskeletal pain and infirmity syndrome presumptively representing the cumulative effect of:

a. Cervical and lumbosacral posttraumatic and degenerative arthropathy without obvious central compression neuropathy.
b. Age appropriate appendicular osteoarthritis.
c. Bilateral posttraumatic and degenerative knee arthropathy status post arthroscopies.
d. Posttraumatic and degenerative left foot pain status postsurgical intervention.
e. Morbid obesity and physical deconditioning.
f. A major element of nonorganic amplification associated with chronic mental health issues to include depression/anxiety associated with intractable psychosocial life stressors.
g. Left wrist, carpal tunnel syndrome.

44. In his report, Dr. Haselwood opined "there is no credible evidence that fibromyalgia or psoriatic arthritis or any other systemic rheumatologic affliction played a role in [respondent's] decision making to stop work [in late 2013]." He added that based on the "quite limited rheumatologically relevant evidence" he could not confirm that respondent is or was afflicted with the fibromyalgia syndrome. It was Dr. Haselwood's conclusion that in respondent's case, fibromyalgia was being used as a convenient "defaulted diagnosis" for "a much a more complex and convoluted musculoskeletal pain and dysfunction syndrome associated with major mental health issues."

45. Upon examination, there were "subtle but significant joint findings consistent with active synovitis" in the hands, wrists and ankles. Based on these findings and his review of respondent's medical records and treatment, Dr. Haselwood concluded that respondent had "modestly active and inadequately controlled psoriatic arthritis." He opined that due to this condition, respondent lacked the stamina to frequently use her hands in repetitive manual manipulation, frequently stand, or lift or carry more than 10 pounds. For these reasons, he concluded that respondent was temporarily substantially incapacitated from the performance of her job duties. He also concluded that respondent's vocational incapacity related to psoriatic arthritis began on or about May 12, 2016, and was anticipated to continue for duration of six months to a year from the time of his examination.

46. In a supplemental report, dated October 28, 2016, Dr. Haselwood emphasized that medical records correlating with the time respondent stopped working in 2013, did not document "credible and unequivocal" documentation that an inflammatory arthritis, psoriatic or otherwise, was a source of respondent's physical impairment. The medical records reflected that it was not until after Dr. Lal's August 2015 rheumatologic evaluation that the potential for a "component of psoriatic arthritis" was added to the respondent's diagnoses of osteoarthritis and fibromyalgia. He noted that "unequivocal evidence" of psoriatic arthritis was not described or aggressively treated until May, 12, 2016, and Dr. Lal did not describe an onset date in his report or specify that the condition was the cause of respondent's retirement from work in 2013.

47. In his supplemental report, Dr. Haselwood opined that it may have been possible that respondent's psoriatic arthritis predated and played a factor in her decision to stop working in 2013. However, there was insufficient evidence in the medical records he reviewed and respondent's description of her history to conclude that she had psoriatic arthritis of sufficient severity to preclude her from performing the physical requirements of her position, until early 2016.

48. Dr. Haselwood's testimony at hearing was consistent with the findings and conclusions specified in his IME reports. He reiterated his opinions and their bases. He emphasized that based on all the information available to him it would be "an unreasonable stretch of credibility" to conclude that psoriatic arthritis precluded respondent from continuing to perform her duties as of the date she last worked for CDCR, in 2013.

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49. Dr. Lopez is a board certified adult psychiatrist. He has been a practicing psychiatrist since 1983. He was scheduled to perform an IME on respondent, on September 21, 2017, to determine whether there were any specific job duties she was unable to perform due to a psychiatric condition. Respondent did not appear for the IME as scheduled.

50. Dr. Lopez reviewed the medical records that were available to him and prepared an eight-page report regarding respondent's capacity to perform her former job duties. Those records Dr. Lopez reviewed included the evaluation reports prepared by Drs. Henrichsen, Haselwood, Barnett, Ambrose, and Schneider, mentioned above. The records also included several medical notes and records from respondent's treating physicians.

51. Based on Dr. Lopez's review of the available records, he concluded that there were no specific job duties that respondent was unable to perform due to a psychiatric condition. He acknowledged that respondent had been previously diagnosed by Dr. Schneider as having an adjustment disorder, and being disabled on a psychiatric basis. It was Dr. Lopez opined that having an adjustment disorder, as described in Dr. Schneider's report, was "not a severe diagnosis" and was not labor disabling.

Discussion

52. Respondent sought disability retirement on the basis of orthopedic (back and neck), psychological (depression and anxiety), and rheumatologic (psoriatic arthritis) conditions. There was no competent medical opinion presented at hearing to establish that respondent is substantially incapacitated due to any of these conditions.

53. Dr. Henrichsen persuasively testified that respondent's back and neck conditions are not substantially disabling. His opinions were thoroughly supported in three separate IME reports and explained at hearing. He emphasized that his findings were supported not only by his own examination findings, but also the consistent dearth of objective findings in the records to support respondent's claimed incapacity.

54. The testimony of Drs. Haselwood and Lopez were similarly persuasive and supported by their detailed IME reports. There was no competent medical evidence presented at hearing to support that respondent had even been diagnosed with psoriatic arthritis prior to the last day she worked for CDCR. Dr. Lopez found that respondent's diagnosed depression, anxiety, and adjustment disorder were not severe enough to be labor disabling or prevent her from performing any of her job duties.

55. Although respondent submitted copies of psychological reports, chiropractic reports, and a fitness for duty evaluation report, which all indicate that respondent was either temporarily or permanently unable to perform her essential job duties, these reports were not persuasive. Because the authors of these reports were not available at hearing for cross-examination, their opinions were admitted only as administrative hearsay and cannot be relied upon, standing alone, to support any findings as to respondent's claimed incapacity. (Gov. Code, § 11513, subd. (d).)

56. In addition, the reports themselves do not fully support respondent's asserted incapacity. The reports appear to have been prepared to assist with determinations applicable to workers' compensation claims rather than for CalPERS disability retirement proceedings. Dr. Schneider's most recent evaluation report, dated May 19, 2015, actually specifies that respondent "has no psychiatric symptoms that would interfere with [her performance of] her job." Each of Dr. Ambrose's chiropractic reports specify that respondent should be precluded from repetitive bending and repetitive light or heavy lifting, those limitations alone do not establish that when respondent applied for disability retirement, she was substantially and permanently incapacitated from performing the usual duties of a Pharmacy Technician for CDCR.

57. Dr. Templeton's fitness for duty evaluation does not appear to utilize the appropriate standard for determining whether an applicant for disability retirement is substantially incapacitated from the performance of their former job duties. She acknowledges that she cannot identify "the etiology of [respondent's] pain," but concludes that respondent cannot perform her essential job functions due to her unsupported chronic pain and narcotic dependence. Dr. Templeton's conclusions are not supportive of

respondent's application for disability retirement because they appear to be based solely on respondent's subjective complaints of pain rather than competent medical opinion. (Gov. Code, § 20026.)

58. The burden was on respondent to present competent medical evidence to establish that she is permanently and substantially incapacitated for the performance of her usual job duties. She failed to do so. She produced a substantial amount of reports of subjective complaints of pain without corresponding and supportive objective medical findings. She produced hearsay medical reports and medical records. She did not call a medical expert to testify at hearing. There was no indication in respondent's medical reports that the doctors evaluated respondent according to the standards applicable to a CalPERS disability retirement proceeding. To the extent the doctors who authored those reports applied evaluation standards applicable in workers' compensation cases, their opinions can be given little weight. When all the evidence is considered, respondent did not submit sufficient evidence to meet her burden. Consequently, her disability retirement application must be denied.

LEGAL CONCLUSIONS

1. By virtue of respondent's employment as a Pharmacy Technician for the CDCR, respondent is a local miscellaneous member of CalPERS, subject to Government Code section 21151.[2]

2. To qualify for disability retirement, respondent had to prove that, at the time she applied, she was "incapacitated physically or mentally for the performance of [his] duties." (Gov. Code, § 21156.) As defined in Government Code section 20026:

> "Disability" and "incapacity for performance of duty" as a basis of retirement, mean disability of permanent or extended and uncertain duration, as determined by the board . . . on the basis of competent medical opinion.

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

> (a) Any patrol, state safety, state industrial, state peace officer/firefighter, or local safety member incapacitated for the performance of duty as the result of an industrial disability shall be retired for disability, pursuant to this chapter, regardless of age or amount of service.
>
> (b) This section also applies to local miscellaneous members if the contracting agency employing those members elects to be subject to this section by amendment to its contract.

3. In *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876, the court interpreted the term "incapacity for performance of duty" as used in Government Code section 20026 (formerly section 21022) to mean "the *substantial* inability of the applicant to perform his usual duties." (Italics in original.) The court in *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 855, 863, explained that prophylactic restrictions that are imposed to prevent the risk of future injury or harm are not sufficient to support a finding of disability; a disability must be currently existing and not prospective in nature. In *Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, the court found that discomfort, which may make it difficult for an employee to perform his duties, is not sufficient in itself to establish permanent incapacity. (See also, *In re Keck* (2000) CalPERS Precedential Bd. Dec. No. 00-05, pp. 12-14.)

4. The standards in CalPERS disability retirement cases differ from those in workers' compensation. (*Bianchi v. City of San Diego* (1989) 214 Cal.App.3d 563, 567; *Kimbrough v. Police & Fire Retirement System* (1984) 161 Cal.App.3d 1143, 1152-1153; *Summerford v. Board of Retirement* (1977) 72 Cal.App.3d 128, 132 [a workers' compensation ruling is not binding on the issue of eligibility for disability retirement because the focus of the issues and the parties are different].)

5. When all the evidence in this matter is considered in light of the analyses in *Mansperger, Hosford, Smith*, and *Keck*, respondent did not establish that her disability retirement application should be granted. She failed to submit sufficient evidence based upon competent medical opinion that, at the time she applied for disability retirement, she was permanently and substantially incapacitated from performing the usual duties of a Pharmacy Technician for CDCR. Consequently, her disability retirement application must be denied.

ORDER

The application of respondent Shauna Lea Butler for disability retirement is DENIED.

DATED: January 8, 2018

DocuSigned by:
Ed Washington
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ED WASHINGTON
Administrative Law Judge
Office of Administrative Hearings