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:
RACHELLE BARONE,
Respondent,
and
CALIFORNIA DEPARTMENT OF
CORRECTIONS AND
REHABILITATION,
Respondent.

CalPERS No. 2017-0534
OAH No. 2017101047

PROPOSED DECISION

This matter was heard before Erin R. Koch-Goodman, Administrative Law Judge, Office of Administrative Hearings, State of California, on June 22, 2018, in Sacramento, California.

The California Public Employees’ Retirement System (CalPERS) was represented by Rory Coffey, Senior Staff Counsel.

Rachelle Barone (respondent) was present and represented herself.

There was no appearance by or on behalf of respondent California Department of Corrections and Rehabilitation (CDCR). The matter proceeded as a default against CDCR pursuant to California Government Code section 11520, subdivision (a).

Evidence was received, the record was closed, and the matter was submitted for decision on June 22, 2018.
ISSUE

Is respondent permanently disabled or substantially incapacitated from the performance of her usual and customary job duties as a Correctional Officer (CO), for CDCR, based upon her orthopedic (right shoulder) condition?

FACTUAL FINDINGS


2. On October 27, 2016, respondent filed an application for industrial disability retirement (application), claiming a disabling injury to her right shoulder. At the time she filed her application, respondent was employed by CDCR as a CO. By virtue of her employment, respondent was a state safety member of CalPERS subject to Government Code section 21151, subdivision (a). On October 27, 2016, respondent also filed an application for service retirement. Respondent retired for service effective August 2, 2016, and has been receiving her retirement allowance from that date.

3. For her application, CalPERS reviewed respondent’s medical documentation regarding her right shoulder and sent respondent for an Independent Medical Examination (IME) with Robert Henrichsen, M.D., an orthopedic surgeon. Based on the above, on March 2, 2017, CalPERS denied respondent’s application on the grounds that respondent’s condition was not disabling and she was not substantially incapacitated from the performance of her job duties as a CO with CDCR. Respondent filed an appeal on March 20, 2017.

Job Duties

4. With her application, respondent submitted a CDCR Essential Functions list for a CO. The CDCR Essential Functions list includes the following items affecting respondent’s physical condition:

   • Must be able to swing baton with force to strike an inmate.
   • Disarm, subdue, and apply restraints.
   • Defend self against an inmate armed with a weapon.
   • Lift and carry continuously to frequently; lift and carry in the light (20 pounds maximum) to medium (50 pounds maximum) range frequently throughout the workday and in the very heavy lifting range (over 100 pounds) occasionally; lift and carry an inmate and physically restrain the inmate.
including wrestling an inmate to the floor; drag/carry an inmate out of a cell; perform lifting/carrying activities while working in very cramped spaces.

- Pushing and pulling occasionally to frequently; push and pull while opening and closing locked gates and cell doors throughout the work day; pushing and pulling may also occur during an altercation or the restraint of an inmate.

- Reaching occasionally to continuously; reach overhead while performing cell or body searches, etc.

- Arm movement occasionally to continuously.

- Bracing occasionally; brace while restraining an inmate during an altercation, or while performing a body search.

Prior Industrial Injury – Right Shoulder

5. On August 10, 2009, respondent injured her right shoulder while working as a teacher’s aide for the Elk Grove Unified School District. A right shoulder arthroscopic surgery was performed in 2009 by Randall Schaefer, M.D., orthopedic surgeon. Respondent was off work for one month, on modified work for two months, and then returned to full duties.

Current Industrial Injury – Right Shoulder

6. On March 9, 2015, respondent was inspecting a freight truck leaving the facility. She attempted to lift the rollup door on the back of the truck; the door jammed in place, and respondent felt a pop and pain in her right shoulder. Respondent reported the injury to CDCR and was referred to Helen Weinrit, M.D., Kaiser Permanente Occupational Medicine. Dr. Weinrit saw respondent on April 9, 2015. A physical examination revealed no swelling, ecchymosis, or mass of the right shoulder, but tenderness posteriorly; with reduced shoulder rotation, flexion 160 degrees, and abduction 140 degrees. Dr. Weinrit diagnosed respondent with a right shoulder sprain, prescribed ice and a non-steroidal anti-inflammatory drug (NSAID), and took respondent off work.

7. On April 16, 2015, Dr. Weinrit reassessed respondent, finding better range of motion, but continued symptoms of impingement. An x-ray was taken, revealing sclerotic changes of the humeral head and rotator cuff tendinopathy. Dr. Weinrit referred respondent to physical therapy (PT). PT began on April 16, 2015. PT assessed respondent, finding rounded shoulders, head forward, with thoracic kyphosis; flexion 121 degrees, abduction 100 degrees, external rotation 42 degrees; internal rotation normal and impingement abnormal. PT continued on April 20, 23, and 30, 2015. On April 30, 2015, Dr. Weinrit reassessed
respondent. Respondent expressed relative comfort while sitting, but pain with flexion and abduction, and numbing in the fifth finger a few days prior.

8. On May 3, 2015, respondent had an MRI, revealing type 2 acromion, with a tiny undersurface tear of the supraspinatus and infraspinatus tendon; bicep tendons intact; musculature above rotator cuff normal; and AC joint clear with no significant bursal fluid identified. On or about May 11, 2015, Dr. Weinrit released respondent to return to work with modified duties. On May 13, 2015, Dr. Weinrit saw respondent. Respondent described intermittent tingling of the first and fifth fingers. Dr. Weinrit offered a steroid injection; respondent refused. PT continued on June 12, 15, 19, and 22, 2015. On June 22, 2015, Dr. Weinrit saw respondent. Respondent reported shoulder pain and range of motion limited to 150 degrees. Dr. Weinrit released respondent to return to work with modified duties, and referred her to Howard Jackson, M.D., orthopedic surgeon, Kaiser.

9. On June 23, 2015, Dr. Jackson saw respondent and conducted a physical examination. Dr. Jackson found no atrophy; flexion 150 degrees, abduction 90 degrees; strength good with abduction and external rotation. Reviewing imaging, Dr. Jackson diagnosed respondent with rotator cuff tendonitis, and symptoms related to persistent impingement. Dr. Jackson recommended a subacromial space steroid injection and/or a subacromial decompression surgery; respondent agreed to the injection and surgery. On July 7, 2015, Dr. Weinrit saw respondent. Respondent described pain with flexion and abduction. On July 20, 2015, Dr. Jackson performed a subacromial decompression surgery on respondent, with a post-surgical diagnosis of “possible type 1 labral tear of the superior labrum”; with some fraying at the bicep anchor; some degeneration at the rotator cuff, but no complete tear; mild bursitis debrided; joint and bicep tendon intact; subscapular tendon normal; glenohumeral joint intact with no loose bodies in the joint; good decompression with no evidence of bony impingement; and a pristine rotator cuff attachment. On July 30, August 10, and 30, 2015, Dr. Jackson saw respondent.

10. PT was restarted on August 10, 2015. On August 18, 2015, Dr. Weinrit saw respondent. Respondent complained of burning in the anterior shoulder portal, with tenderness of the anterior scar. Dr. Weinrit tested flexion at 90 degrees and abduction at 90 degrees. Dr. Weinrit ordered respondent to continue with ice and PT. PT continued on August 18, 25, 27, and September 2, 2015. On September 8, 2015, Dr. Jackson saw respondent. Respondent reported clicking in the shoulder and Dr. Jackson suggested modified exercises and continued respondent off work. PT continued on September 8, 11, 15, 18, 22, and 25, 2015. On September 29, 2015, Dr. Weinrit saw respondent. Respondent reported aching and popping in her right shoulder. Dr. Weinrit continued modified work, but respondent reported CDCR would not accommodate a request for modified duty. On September 30, 2015, Dr. Jackson saw respondent. Dr. Jackson found full flexion, but limited endurance and stamina. He returned respondent to work with modified duties. PT continued on October 2, 20, November 5, and 11, 2015.

11. On November 13, 2015, Dr. Weinrit saw respondent, finding no clicking, but reduced range of motion in flexion and abduction, with pain and tightness at the end of
rotation. PT continued on November 23, 2015. On December 3, 2015, Drs. Weinrit and Jackson saw respondent and she continued with PT. On January 4, 2016, Dr. Weinrit saw respondent and respondent reported feeling no better after the surgery; respondent continued PT.

12. On January 7, 2016, Dr. Jackson saw respondent, finding a full range of motion, but respondent reported pain when reaching overhead. Dr. Jackson continued respondent on modified work duties. On February 1, 2016, Dr. Weinrit saw respondent. On February 4, 2016, Dr. Jackson saw respondent, finding normal range of motion. Dr. Jackson ordered an MRI. On March 11, 2016, Dr. Weinrit saw respondent. On March 15, 2016, respondent had an MRI, revealing no full-thickness rotator cuff tear; minimal tendinosis; with intact bicep tendon; muscle volume normal with no inflammatory bursitis; articular surface intact; AC joint arthritis; type 1 acromion; and no supraspinatus outlet narrowing. The diagnosis included tendinosis of the supra and infraspinatus tendons, some AC joint pathology without undersurface osteophyte formation and no full-thickness of the rotator cuff tear. On March 22, 2016, Dr. Jackson saw respondent. Respondent reported crepitus with active motion exercises.

13. On April 8, 2016, Dr. Weinrit saw respondent. Respondent reported intermittent pain and felt she was unable to swing a baton with her right arm. Dr. Weinrit found respondent in no distress at full flexion, but some pain and tightness with abduction. On April 12, 2016, Dr. Jackson saw respondent. Respondent reported restricting her use of the right shoulder due to pain. PT continued on April 21, 28, and May 4, 2016. On May 6, 2016, Dr. Weinrit saw respondent. Respondent reported intermittent pain with popping, clicking and fatigue with exercise. Dr. Weinrit examined respondent, finding full flexion with some pain and tightness with abduction at the end of rotation. On May 11, 2016, Dr. Jackson saw respondent. On June 11, 2016, Dr. Weinrit saw respondent. Respondent described pain and tightness at the end of rotation. On June 30, 2016, Dr. Weinrit saw respondent, finding respondent to be Permanent and Stationary with a one percent whole body impairment. On November 7, 2016, Dr. Weinrit completed a Physician's Report on Disability, describing a permanent tenderness in the shoulder, with work restrictions including no forceful movement of the right arm and occasional pushing and pulling of the right arm when extended. As a result, Dr. Weinrit found respondent to be substantially incapacitated.

Worker's Compensation Panel Medical Evaluation — Thomas S. Pattison, M.D.

14. On September 19, 2017, Dr. Pattison completed a panel medical evaluation of respondent; a second opinion requested by respondent following Dr. Weinrit’s permanent and stationary assessment finding one percent whole body impairment. Dr. Pattison interviewed respondent, took a medical history and an accounting of respondent’s current complaints; reviewed respondent’s medical files; and completed a physical examination of respondent. Dr. Pattison did not review any imaging, but read the corresponding reports. On September 19, 2017, Dr. Pattison wrote a Report. Dr. Pattison did not testify at hearing.
15. Dr. Pattison's physical examination of respondent revealed the following: Cervical spine – flexion 55 degrees, extension 44 degrees, lateral titling bilaterally 42 degrees, rotation bilaterally 75 degrees. Spurling's test negative. Some increased myofascial tenderness in the trapezius bilaterally, but no widespread myofascial tenderness. Posture somewhat forward leaning with slightly rounded shoulders. No atrophy. Muscles normal in tone. Muscle strength 5/5 in shoulder forward flexors, abductors, external rotators, internal rotators, elbow flexors, elbow extendors, wrist extenders and flexors, and hand intrinsics and extensor indicis proprius bilaterally, except for 5-/5 strength at the end range at right shoulder. Deep tendon reflexes symmetrical at 2/4 at the biceps, brachioradialis and triceps. Appreciation of tactile and sharp stimuli in right and left upper extremities normal and symmetrical in all dermatomes between C4 and T1. Bilateral shoulder range of motion normal in forward flexion, abstraction, internal rotation, external rotation, extension, and adduction. Normal range of motion for elbows, wrists, and fingers bilaterally. No high grade shoulder impingement signs present on the left, but impingement is present on the right. Some crepitus at the end of range in right shoulder. Thoracic outlet neurotension signs are negative. No swelling in any upper extremities joints. Skin and pulses intact. Good capillary refill at the fingertips. No tenderness at the lateral or medical elbow epicondylar areas bilaterally. Finkelstein test negative. Reverse Phalen's tests and Phalen's test negative. Tinel's test is negative over the elbows and wrists. For the thoracic spine: no tenderness along the spinous processes. Scapulohumeral rhythm intact bilaterally. No evidence of scapular winging. Some mild to slight myofascial tenderness in the shoulder girdle musculature. For the lumbar spine: no hyperreflexia and normal gait.

16. Dr. Pattison rates respondent with a five percent whole person impairment: two percent total upper extremity impairment, plus three percent pain. Under Disability/Work Restrictions, Dr. Pattison notes: "Prophylactically, the following work restrictions would seem to be congenial to the examinee's situation. Thus, per workers' compensation standards, particularly to reduce future medical costs, it would seem to be prudent to agree with her treaters that she is not able to return to work that involves the risk of physical altercation." Under Rehabilitation Status, Dr. Pattison writes: "Per my understanding of relevant California workers' compensation standards, the examinee would be medically eligible for job displacement services if the employer cannot accommodate the above restrictions." Dr. Pattison concludes:

The examinee presents with an injury that seemingly was not all that severe and would typically heal within a month or two, as the injury occurred with a lifting-type mechanism as opposed to a fall. The two MRIs and the surgery all seemed quite reassuring but, unfortunately, the pain persisted. The surgery was notable for no indication of an adhesive capsulitis as there was full range of motion under anesthesia. Unfortunately, her trials to strengthen the shoulder seemed to be quite discouraging as they caused some increased discomfort. She has not followed up with any medical care for the last 14 months, despite having future medical treatment and the ongoing discomfort.
CalPERS Independent Medical Evaluation – Robert Henrichsen, M.D.

17. On February 7, 2017, respondent was seen by Dr. Henrichsen, a retired orthopedic surgeon of 38 years, licensed and Board Certified in Orthopedic Surgery. Dr. Henrichsen conducted an IME. Dr. Henrichsen interviewed respondent, took a medical history and an accounting of respondent’s current complaints; reviewed respondent’s medical files and the CDCR essential functions list for a CO; and completed an orthopedic examination of respondent’s neck and upper extremities. Dr. Henrichsen did not review imaging, but read the corresponding report summaries found within the medical record. On February 7, 2017, Dr. Henrichsen wrote a Report. On March 13, 2018, Dr. Henrichsen wrote a Supplemental Report. He testified at hearing consistent with his reports.

18. Dr. Henrichsen’s physical examination of respondent revealed the following: normal heel-to-toe gait, with arms swinging without restriction. In the sitting position: extension 60/60/60 degrees, flexion 50/60/60 degrees, lateral bending 30/40, 30/40, 35/30 degrees, and rotation 90/90 degrees. Spurling’s sign negative. Normal neck motion. Parascapular muscle function normal: shrug shoulders, abduct scapulae, with no instability to the scapular muscle loading. Shoulders: extension 65/70 degrees, flexion 165/180 degrees, abduction 140/180 degrees, internal rotation 90/90 degrees, external rotation 75/85 degrees and cross-arm adduction 45/50 degrees, range of motion 120 degrees, with intermittent popping in right shoulder. O’Brien’s maneuver produced no bicep related symptoms. O’Brien’s testing, the Speed maneuver, and anterior Speed maneuver produced some shoulder pain, but not bicep pain. Yergason’s maneuver produced no symptoms. Bicep bulges normal and biceps distally intact at radial tuberosity. In the supine position: shoulder is stable. In the standing position: normal pull-through of rotator cuff complex and trapezius latissimus dorsi musculature with no periscapular atrophy.

19. Dr. Henrichsen further found: Elbow pronation 90/90 degrees and supination 90/90 degrees. In the wrist area, radial pulses were 2+. Wrist range of motion was: extension 75/75 degrees, flexion 90/90 degrees, radial deviation 25/30 degrees, and ulnar deviation 45/45 degrees. Hand function intact. Normal strength with intrinsic testing and no extrinsic atrophy. Bicep and triceps reflexes 2+ and equal. Brachioradius reflexes 0/0. Arm circumference 31/31.5 cm and forearms 26/25.5 cm in circumference.

20. Dr. Henrichsen diagnosed respondent with a “right shoulder sprain; history of prior rotator cuff repair right shoulder without medical record documentation; AC joint arthritis; no impingement syndrome identified in right shoulder; and clicking right shoulder with range of motion.” Dr. Henrichsen found respondent not presently incapacitated from the performance of her duties, and found no specific job duties which respondent is unable to accomplish. More specifically, Dr. Henrichsen noted:

She is able to swing a baton and use it. She will have symptoms when she goes far up over head, and she may have the popping sensation. She may have difficulty when swinging far overhead but she is objectively able to do so. Therefore, as I review the
standards from CalPERS, she does not have specific job duties she is unable to perform.

21. Thereafter, at CalPERS's request, Dr. Henrichsen reviewed the September 19, 2017 report by Dr. Pattison. Dr. Henrichsen wrote a Supplemental Report, noting substantially similar findings by both doctors. As such, Dr. Henrichsen's opinion was unchanged by Dr. Pattison's findings.

Discussion

22. When all of the evidence is considered, Dr. Henrichsen's testimony is credited. Dr. Henrichsen is a Board-Certified orthopedic surgeon. He has experience conducting medical evaluations and providing opinions using the CalPERS standard. Using this standard, Dr. Henrichsen based his opinion on his review of the CO essential functions list, medical records, diagnostic imaging reports, and a physical examination. The examination and review of records led Dr. Henrichsen to conclude that no objective finding preclude respondent from performing her usual and customary duties as a CO for CDCR, based upon an orthopedic condition – right shoulder.

23. Respondent offered a report from Dr. Pattison to support her application. However, Dr. Pattison did not evaluate respondent using the CalPERS standard. Instead, Dr. Pattison evaluated respondent under the worker's compensation standard; where subjective complaints of pain are considered in making a percentage finding of permanent and stationary for the ultimate purpose of monetizing the damage to the injured employee and establishing eligibility for job displacement services. For all the above reasons, respondent failed to present competent medical evidence to support her assertion that at the time she filed her industrial disability application she was substantially incapacitated from the performance of his usual and customary duties as a CO for CDCR.

LEGAL CONCLUSIONS

1. Any state safety member incapacitated for the performance of duty as the result of an industrial disability shall be retired for disability. (Gov. Code, § 21151, subd. (a).) Disability as a basis of retirement means disability of permanent or extended and uncertain duration. (Gov. Code, § 20026.) According to Government Code section 21156, subdivision (a)(1), "[i]f the medical examination and other available information show to the satisfaction of the board . . . that the member in the state service is incapacitated physically or mentally for the performance of his or her duties and is eligible to retire for disability, the board shall immediately retire him or her for disability."

difficulty in performing certain tasks is not enough to support a finding of disability. (Hosford v. Board of Administration (1978) 77 Cal.App.3d 854; Mansperger v. Public Employees' Retirement System, supra, at pp. 876-877 [fish and game warden’s inability to carry heavy items did not render him substantially incapacitated because the need to perform such task without help from others was a remote occurrence].) And mere 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, supra, at p. 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. (Id. at p. 863.) Prophylactic restrictions are designed to prevent future injuries. A condition or injury that may increase the likelihood of further injury, as well as a fear of future injury, do not establish a present “substantial inability” for the purpose of receiving disability retirement. (Hosford v. Board of Administration, supra, at pp. 863-864.)

Determination

3. Respondent has not demonstrated through competent medical evidence that she is substantially incapacitated from performing her normal and usual employment duties as a CO, by reason of the matters set forth in the Factual Findings as a whole.

4. Accordingly, as set forth in the Factual Findings and Legal Conclusions as a whole, respondent has not met her burden of proving by a preponderance of the evidence that she is permanently incapacitated from the substantial performance of her job duties as a CO.

ORDER

The application of Rachelle Barone for CalPERS Industrial Disability Retirement is DENIED.

DATED: July 23, 2018

ERIN R. KOCH-GOODMAN
Administrative Law Judge
Office of Administrative Hearings