

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:**

RANDI D. SULLIVAN and

**PELICAN BAY STATE PRISON, CALIFORNIA DEPARTMENT OF
CORRECTIONS AND REHABILITATION, Respondents**

OAH No. 2018120668

Agency Case No. 2018-1063

PROPOSED DECISION

Sean Gavin, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on June 26, 2019, in Sacramento, California.

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

Jim Fallman, Esq., represented Randi D. Sullivan (respondent), who was present throughout the hearing.

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM
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There was no appearance by or on behalf of respondent Pelican Bay State Prison, California Department of Corrections and Rehabilitation (CDCR). The matter proceeded as a default against CDCR pursuant to California Government Code section 11520, subdivision (a).

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on June 26, 2019.

ISSUE

Was respondent at the time of her application for industrial disability retirement permanently disabled or substantially incapacitated from the performance of her usual and customary job duties as a Registered Dental Assistant (RDA), for CDCR, based upon her orthopedic (bilateral hand/wrist) condition?

FACTUAL FINDINGS

1. On December 19, 2018, Anthony Suine, Chief, Benefit Services Division, CalPERS, made and filed the Statement of Issues in his official capacity.
2. On May 24, 2018, respondent filed an application for industrial disability retirement (application), claiming a disabling injury to both hands and both wrists. At the time she filed her application, respondent was employed by CDCR as an RDA. By virtue of her employment, respondent is a state safety member of CalPERS subject to Government Code section 21151.

Application

3. In her application, respondent indicated: her disability was "both hands and both wrists;" the disability occurred on August 19, 2014; and that it "just start [*sic*] hurting." She listed as her limitation/preclusions due to her injury: "can't do my RDA functions, can't ass[is]t very long because it hurts my hands and wrist, can't do a lot of writing (paperwork)." She is not currently working in any capacity, having last worked in May 2018.

4. CalPERS reviewed respondent's medical documentation regarding her orthopedic condition and sent respondent for an Independent Medical Examination (IME) with Harry Khasigian, M.D., an orthopedic surgeon. Based on the above, on September 12, 2018, CalPERS denied respondent's application on the grounds that her condition was not disabling and she was not substantially incapacitated from the performance of her job duties as an RDA with CDCR. Respondent filed an appeal on October 5, 2018.

Job Duties

5. With her application, respondent submitted a Physical Requirements of Position/Occupational Title form for her position. The form provides the following information about the physical requirements of the RDA position:

- a. Occasional Tasks (up to three hours): sitting; standing; walking; kneeling; climbing; squatting; twisting at the waist; reaching above shoulder; pushing and pulling; keyboard use; mouse use; walking on uneven ground; exposure to excessive noise; exposure to extreme temperature, humidity, wetness; exposure to dust, gas, fumes, or chemicals; and operation of foot controls or repetitive movement.

- b. Frequent Tasks (three to six hours): sitting; standing, walking; bending the neck; bending at the waist; twisting the neck; twisting at the waist; reaching below shoulder; pushing and pulling; power grasping; lifting/carrying 0-10 pounds; lifting/carrying 11-25 pounds; exposure to excessive noise; exposure to dust, gas, fumes, or chemicals; and working with bio-hazards.
- c. Constant Tasks (over six hours): bending the neck; bending at the waist; twisting the neck; reaching below shoulder; fine manipulation; simple grasping; and repetitive use of hand(s).

6. CDCR also submitted an essential functions list for an RDA. The relevant physical functions include:

- Have and maintain sufficient strength, agility, and endurance in order to respond during stressful or emergency (physical, mental, and emotional) situations without compromising the health and wellbeing of self or others;
- Lift and carry occasionally to frequently, in the light (up to 20 pound maximum) range;
- Push, pull, and grip occasionally to frequently to constantly;
- Reach . . . occasionally to frequently, to sufficiently inspect . . . manipulate, and move objects 360 degrees horizontally, from floor through overhead levels;

- Use fingers and hands steadily, occasionally to frequently;
- Use and operate common office machines/equipment including telephones, cellular telephones, photocopiers, fax machines, personal computers, laptops, keyboards, video display terminals, printers, mail machines/scales/meters, calculators, and similar equipment to complete assigned duties; and
- Manipulate patient utilized equipment (e.g., durable medical equipment) in a safe manner.

Respondent's Evidence

RESPONDENT'S TESTIMONY

7. Respondent is 52-years-old. She has worked in the dental field for 35 years. At CDCR, she assisted dentists with dental procedures. Her job required her to retract tongues and cheeks, handle and pass instruments, take impressions, keep chart notes, and assist in surgeries. She had contact with level 4 inmates, who pose the greatest risk of danger to the public.

8. Beginning in approximately August 2014, respondent began to experience pain in her wrists and fingers while at work. She had difficulty retracting tongues and cheeks for extended periods. Over time, respondent began to lose grip strength in both hands and wrists. She began to drop things. On one occasion, in 2018, she dropped an entire tray of dental instruments. This was particularly

worrisome to respondent because level 4 inmates pose the greatest risk of using such instruments as weapons. Respondent began to fear for her own safety and the safety of her coworkers and other inmates.

9. Respondent's pain continued to get worse. She began to compensate for her pain and weakness by modifying her posture. This caused her pain to radiate up her forearm. She also began to experience pain in her neck and back. She tried taking time off from work, but the pain reappeared each time she returned. In 2018, she assisted on a two-hour surgery, and she "could not keep up with the blood" due to her pain. She is concerned that her pain and weakness will lead to patient injury.

TESTIMONY OF DR. EVERETT D. ALLEN, M.D.

10. At hearing, respondent called Dr. Everett D. Allen, M.D., to testify. Dr. Allen graduated from Harvard University in 1973 with a bachelor's degree in biology. In 1976, he graduated from Purdue University with a master's degree in biology. He then attended the Medical Scientist Training Program in Biochemistry/Biophysics at the University of California at San Francisco (UCSF) from 1977 through 1983. He earned his medical degree and completed his residency at UCSF in Internal Medicine from 1984 through 1986. Dr. Allen became a licensed physician in California in 1986.

11. From 2006 to the present, Dr. Allen has worked as a private medical-legal consultant. His license with the Medical Board of California (MBOC) has been disciplined multiple times. His license was suspended from 2009 to 2010. In addition, his license has been on probation since 2009; it is scheduled to remain on probation until 2023. As a condition of his probation, he was not permitted to see patients for several years. He resumed seeing patients in 2018.

12. Dr. Allen did not personally examine respondent. He interviewed her, took a medical history, and reviewed some of her medical records. He did not diagnose her, and did not offer a diagnosis at hearing. Rather, Dr. Allen based his opinion on a review of: (1) reports prepared by respondent's Qualified Medical Examiner (QME), Dr. Gerard H. Dericks, M.D.; (2) the notes of respondent's treating physician, Dr. Kevin J. Caldwell, M.D.; (3) a review of medical journals; and (4) his interview with respondent. Dr. Allen chronicled his opinion in a written report. He testified consistent with the report.

13. In his report, dated May 28, 2019, Dr. Allen wrote the following:

[I]n her early presentation and examinations, some of her electrodiagnostic studies were negative. Over time, these tests became positive. Suggesting that the mechanics of her work maneuvers enhanced the mechanisms producing her symptoms, which is typical for repetitive stress/strain injuries.

REPORT OF DR. GERARD H. DERICKS, M.D.

14. In 2015, the State Compensation Insurance Fund sent respondent to see Dr. Dericks as a QME for her worker's compensation claim. He evaluated her in September 2015, November 2016, April 2018, and April 2019. Each evaluation was conducted using the worker's compensation standard. Dr. Dericks did not testify.

15. Following his April 2019 evaluation of respondent, he created a QME report, dated May 7, 2019 (QME report).¹ In it, he wrote:

Again, clinically, her symptoms appeared to be consistent with carpal tunnel type symptoms. She had a positive Phalen's test and Tinel's sign bilaterally. There was positive pain to palpation of her bilateral wrists. Range of motion was full, but after one motion she became very progressively weak immediately. There was minimal flattening of the opponens [muscle] bilaterally, right greater than left.

16. In his May 7, 2019 report, Dr. Dericks summarized his diagnostic impressions from his previous evaluation of respondent, on April 12, 2018.² He wrote: "Forme fruste carpal tunnel syndrome, bilateral, increasingly symptomatic and painful;" "[r]ight sided cubital tunnel syndrome, with supportive electrodiagnostic data, confirming diagnosis, with decreased elbow conduction velocity noted;" and "[b]ilateral hand pain, cause undetermined, rule our rheumatologic causation versus radiculopathy, due to multilevel cervical disc disease (most likely)."

17. Based on his evaluations, Dr. Dericks recommended that respondent be precluded from lifting; carrying; pushing or pulling more than 10-15 pounds; and repetitive and/or prolonged gripping, grasping, fine manipulation, and any repetitive

¹ The QME report was admitted as administrative hearsay and considered to the extent permitted under Government Code section 11513, subdivision (d).

² Respondent did not submit a QME report for the April 12, 2018 evaluation.

hand use. He further concluded that respondent was not capable of performing her usual and customary job as an RDA.

LETTER FROM DR. KEVIN J. CALDWELL, M.D.

18. Respondent also submitted a letter from Dr. Kevin J. Caldwell, M.D., respondent's treating physician since August 2014. In his letter, dated October 3, 2018, Dr. Caldwell wrote:

In my medical opinion [respondent] is unable to do any repetitive movements with her bilateral upper extremities. She is currently employed as a dental assistant and she is no longer able to perform her job functions. My patient would also not be able to be relocated to another position such as office staff as she is unable to do any type of repetitive motion which would include typing, computer work or use of a mouse.

19. Dr. Caldwell did not testify, and respondent did not submit evidence regarding Dr. Caldwell's diagnostic methods or objective findings.

CalPERS's Evidence - Testimony of Dr. Harry Khasigian, M.D

20. CalPERS sent respondent for an IME with Dr. Khasigian, an orthopedic surgeon with 40 years of experience. He graduated from the University of Southern California (USC) in 1970 with a bachelor's degree. He then graduated from USC in 1974 with a medical degree. He completed an internship at USC from 1974 through 1975 and completed his orthopedic residency at the University of California, Irvine, from 1975 through 1979.

21. Dr. Khasigian is Board Certified by the American Board of Orthopedic Surgery, with a subspecialty in Orthopedic Sports Medicine; a Fellow with the American Academy of Orthopedic Surgeons; a Diplomate with the Arthroscopy Board of North America; a Diplomate with the National Association of Disability Evaluating Physicians; a Fellow with the International College of Surgeons; and a Qualified Medical Examiner for the State of California. Currently, Dr. Khasigian is in private practice in Sacramento.

22. On August 22, 2018, Dr. Khasigian conducted an IME of respondent. Dr. Khasigian conducted his exam using the CalPERS substantial incapacity standard, which is different than the workers' compensation standard. Dr. Khasigian interviewed respondent; took a medical history and an accounting of respondent's current complaints; reviewed respondent's medical charts; and completed an orthopedic examination of respondent's hands and wrists. On September 4, 2018, Dr. Khasigian wrote a report. Dr. Khasigian testified at hearing consistent with his report.

23. Dr. Khasigian's physical examination of respondent revealed the following relevant information:

GENERAL: [Respondent] is a well-developed, well-nourished female. She does not wear any orthopedic devices, appliances, or braces today. She is able to sit and stand without assistance. Her movements are smooth and coordinated.

[¶] . . . [¶]

UPPER EXTREMITIES: Pulses, hair distribution, skin turgor and temperature are normal. Tissues are soft and supple.

The medial and lateral sides of the fingers on the index, ring, and long finger do not show any unusual presentation, masses, macerations, ganglions, scabs, exostosis, or any other unusual entities. MCP [metacarpophalangeal], DIP [distal interphalangeal], PIP [proximal interphalangeal] joint motion is within normal limits. There is no locking or catching and no evidence of trigger fingers. There is no ligamentous instability in the FDP [Flexor digitorum profundus] and FDP [Flexor digitorum superficialis] [tendons], and extensor function is within normal limits. Nails are normal without pitting or other abnormality. There is good capillary filling. There is no interosseous atrophy or other secondary changes. There is normal temperature.

The wrist does [not]³ show any swelling or tenderness about de Quervain's tendons or the distal ulnar joint. There is no crepitus or grinding. There is no tendinous irritation.

There is negative Lachman's of the wrist. There is no pain over the scapholunate space. There is no pain in the snuffbox.

24. Dr. Khasigian also conducted a variety of tests on respondent, including a Jamar Dynamometer. On that test, which measures grip strength in a pistol-grip position, respondent registered a 2 on both her right and left hands. Dr. Khasigian

³ Dr. Khasigian' omission of the word "not" in his report was a typographical error.

explained that a 2 indicates a lack of effort, as patients suffering from carpal tunnel pain typically measure in the range of 20 to 30 on that test.

25. Dr. Khasigian diagnosed respondent with: "(1) Mild right carpal tunnel syndrome per nerve conduction study; (2) Mild left carpal tunnel syndrome per nerve conduction study; (3) No EMG [electromyography] evidence of radiculopathy; (4) Cervical spondylosis without radiculopathy C3-7, mild, per paraphrased MRI report, without clinical correlation; and (5) Hypothyroid." Dr. Khasigian concluded that, based on her clinical examination, "there is no objective abnormality and therefore [respondent] is able to perform all of her usual and customary work activities." Furthermore, he concluded that respondent "is not substantially incapacitated as she presents with no limitations from her usual and customary work at this time on an objective basis." Dr. Khasigian found respondent to be cooperative, but noted "her subjective complaints at a level 10 in the face of a normal clinical examination shows that there is a significant disassociation between the subjective and objective presentations." In sum, Dr. Khasigian found:

Current clinical examination is entirely within normal limits. She has full range of motion of all of her extremities. She has no neurological deficits. She has no contractures, malalignment, or other evidence of abnormality.

Her level of carpal tunnel is not evident clinically. It also, if present, would be completely amenable to surgical release which should restore normal function. In and of itself, those syndromes, carpal and cubital tunnel are not disabling at a status that is below treatment level which is her current situation. Although she has a high level of subjective

complaints with pain reaching a level 10, she does not have any clinical manifestations of limitation, secondary changes, reactive abnormalities, atrophic changes from dysfunction, or any other evidence of clinical abnormality.

Discussion

26. While both Drs. Dericks and Khasigian examined respondent, only Dr. Khasigian testified at the hearing, and only Dr. Khasigian completed an evaluation of respondent using the CalPERS substantial incapacity standard. Dr. Allen did not examine respondent and did not offer a diagnosis; Dr. Dericks used the worker's compensation standard. The CalPERS standard requires objective findings to support a determination of substantial incapacity to perform the duties of an RDA. Dr. Khasigian points to his physical exam as well as respondent's test results, noting no anatomical findings consistent with respondent's subjective reports of pain. He found, at most, respondent has mild carpal tunnel syndrome, which does not preclude her from performing an RDA's job functions. Respondent may have pain, but pain is not the threshold for substantial incapacity. Furthermore, Dr. Khasigian noted the disassociation between respondent's subjective reports of pain and the clinical manifestations of limitation or abnormality.

27. Considering all of the medical evidence, Dr. Khasigian's testimony is credited. Dr. Khasigian is a Board Certified orthopedic surgeon with 40 years of experience. He has experience conducting medical evaluations and providing opinions using the CalPERS standard. His conclusions are based on objective medical findings and not on respondent's subjective complaints. Dr. Dericks failed to identify any objective physical conditions that would preclude respondent from performing the

duties of an RDA. Instead, his opinion was shaped by the respondent's subjective complaints of pain. Dr. Allen did not offer any diagnosis at all.

28. Respondent's application seeks disability retirement on the basis of an orthopedic condition; however, her identified orthopedic condition does not cause respondent to be unable to perform the essential functions of the RDA job. Furthermore, there was insufficient evidence to show that, at the time of her application, she was substantially incapacitated from performing her usual job duties.

29. For all the above reasons, respondent failed to establish, through competent medical evidence, that she is substantially incapacitated from performing her usual job duties, based on the orthopedic condition, bilateral hands/wrists. Rather, the persuasive medical evidence established that respondent's orthopedic condition does not, and did not at the time of her application, substantially disable her from performing her usual job duties as an RDA.

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 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."

2. An applicant must demonstrate their substantial inability to perform their usual duties on the basis of competent medical evidence, and not just the applicant's subjective complaints of pain. (*Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697; *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876.) Mere 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*, 6 Cal.App.3d 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*, 77 Cal.App.3d 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. (*Id.* at pp. 863-864.)

3. The burden of proof was on respondent to demonstrate that she is permanently and substantially unable to perform her usual duties such that she is permanently disabled. (*Harmon v. Board of Retirement, supra*, 62 Cal.App.3d 689; *Glover v. Board of Retirement* (1980) 214 Cal.App.3d 1327, 1332.) To meet this burden, respondent must submit competent, objective medical evidence to establish that, at the time of her application, she was permanently disabled or incapacitated from

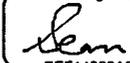
performing the usual duties of her position. (*Harmon v. Board of Retirement, supra*, 62 Cal.App.3d at p. 697.)

4. Respondent failed to provide competent medical evidence sufficient to demonstrate that she was substantially incapacitated from performing her normal and usual employment duties as an RDA at the time she filed her disability retirement application. Accordingly, as set forth in the Factual Findings and Legal Conclusions as a whole, respondent is not entitled to retire for disability pursuant to Government Code section 21150.

ORDER

The application for industrial disability retirement filed by respondent Randi D. Sullivan is DENIED.

DATE: July 25, 2019

DocuSigned by:

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SEAN GAVIN

Administrative Law Judge

Office of Administrative Hearings