ATTACHMENT A

THE PROPOSED DECISION

ATTACHMENT A

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Reinstatement from Disability Retirement of:

AMANDA K. RELVA,

and

CORRECTIONAL TRAINING FACILITY, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION,

Respondents

OAH No. 2019041227

Agency Case No. 2018-1278

PROPOSED DECISION

John E. DeCure, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on September 10, 2019, in Fresno, California.

Helen L. Louie, Attorney, represented the California Public Employees' Retirement System (CalPERS and Complainant).

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM
FILED October 9 20 19
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Respondent Amanda K. Relva was present and represented herself.

There was no appearance by or on behalf of the Correctional Training Facility, Department of Corrections and Rehabilitation (CDCR or Department). CalPERS established that CDCR was properly served with the Notice of Hearing. Consequently, this matter proceeded as a default hearing against CDCR under Government Code section 11520.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on September 10, 2019.

ISSUE

Does respondent remain substantially incapacitated from performance of her usual job duties as an Associate Governmental Program Analyst (AGPA) due to a cardiovascular (heart) condition?

FACTUAL FINDINGS

Jurisdictional Matters and Background

1. Respondent was employed by CDCR at its Correctional Training Facility as an AGPA. Her employment qualified her as a state industrial member. On October 29, 2014, she submitted an application for disability retirement (application) on the

basis of a heart (postural orthostatic tachycardia)[1] condition. Respondent identified the date of injury as October 7, 2012. CalPERS approved the application. Following the approval, respondent retired for disability.[2] Respondent was under the minimum age for voluntary service retirement at the time; pursuant to Government Code section 21192, she was subject to a future medical reexamination to determine whether she continued to qualify for industrial disability retirement.

2. In 2017, CalPERS sought to reexamine respondent to reevaluate her disability. CalPERS also obtained medical reports and records concerning respondent's cardiovascular condition and treatment history. On August 9, 2018, James M. Schmitz, M.D., performed an Independent Medical Examination (IME) of respondent on behalf of CalPERS and concluded that she still qualified for industrial disability retirement. By a letter dated August 15, 2018, CalPERS notified Dr. Schmitz that it disagreed with the opinions and conclusions in his IME and requested that he reconsider several factual and legal issues pertaining to respondent's case, then send CalPERS his "final recommendations and conclusions" by August 22, 2018.

Dr. Schmitz complied with CalPERS' request and wrote a Supplemental IME, dated September 12, 2018. In his Supplemental IME, Dr. Schmitz changed his original

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[1] In the application, respondent erroneously referred to the condition as postural orthostatic "tachaydia."

[2] Although the Accusation alleged respondent "retired for disability effective December 31, 2014," the evidence did not establish a specific retirement date. Because this issue was not contested at hearing, a reasonable presumption may be made that respondent retired in December 2014.

opinion, concluding that respondent was not presently incapacitated from performing the duties of an AGPA. By a letter dated October 8, 2018, CalPERS notified respondent and CDCR of this determination, and notified the parties of their right to appeal. Respondent timely filed a notice of appeal.

3. On April 24, 2019, complainant filed the Accusation at issue in this matter seeking to reinstate respondent to her position as an AGPA with CDCR. Respondent timely filed a notice of defense. All jurisdictional requirements have been met.

Job Duties

4. As set forth in the CDCR Health Care Unit's Essential Functions of an AGPA, an AGPA must be able to perform a wide variety of administrative functions, including working in any correctional institution regardless of level of security, being able to lead others, and functioning under highly stressful circumstances, including working under pressure and tight deadlines.

Physical functions include: responding quickly to emergency situations; maneuvering over varying surfaces, including several flights of stairs; maintaining sufficient strength, agility and endurance during stressful or emergency situations without compromising the well-being of herself or others; maintaining the mental capacity to deal with emergencies including aggressive, violent, verbally abusive inmates and traumatic and unpleasant inmate situations (such as attacks or suicide); and remaining alert and focused in response to dangerous or emergency situations. The AGPA must walk occasionally to frequently, occasionally lift and carry items of up to 20 pounds, push and pull occasionally, sit frequently to continuously, and stoop, bend, reach, twist and stretch occasionally. A variety of other intellectual functions are also required.

5. The CDCR Duty Statement for the Associate Government Program Analyst further details various administrative functions of the position, including monitoring and collecting data, developing corrective actions, reviewing proposals for consistency with policies and procedures, developing training procedures, consulting with staff, conducting audits and surveys, organizing documentation, and monitoring health care coverage and inmate/patient access to health care.

6. According to the CalPERS "Physical Requirements of Position/ Occupational Title" form completed by respondent's employer, the physical requirements of the AGPA position are each set forth in terms of frequency, which is categorized as "never," "occasionally" (up to three hours), "frequently" (three to six hours), and "constantly" (over six hours).

7. The AGPA's primary physical activities and their corresponding frequencies were reported, within a range of never to constant, as follows: running, crawling, working with heavy equipment, working at heights, using visual/auditory equipment, working with biohazards (never); bending the waist (never/occasionally); kneeling, climbing, squatting, reaching above and below the shoulder, pushing and pulling, power grasping, driving, operating foot controls, and being exposed to noise/dust/gas/fumes (occasionally); standing, walking, and twisting the waist (occasionally/ frequently); standing, twisting the waist, and walking on uneven ground (frequently); sitting, bending and twisting the neck, fine manipulation, and simple grasping (frequently/constantly); and performing repetitive use of hands, keyboard and mouse use (constantly).

Regarding lifting and carrying items of a particular weight, and applying the same never-to-constant range, the AGPA must: lift and carrying 0-10 pounds

(frequently), 11-25 pounds (occasionally), 26-50 pounds (occasionally), and never lift or carry over 50 pounds.

Medical Evidence and Evaluation

ORIGINAL IME

8. Dr. Schmitz conducted an IME to determine whether respondent was still incapacitated from her job duties as an AGPA. Dr. Schmitz has been licensed in California since approximately 2016, specializes in cardiology, and is board-certified in cardiology and internal medicine. He practices in Carmel and Monterey. Dr. Schmitz reviewed the employer's AGPA job descriptions and available medical records, obtained a medical history from respondent, and administered a physical examination. Following the IME, he prepared an IME report dated August 9, 2018 (original IME). Later, at CalPERS' request, he submitted a Supplemental IME report, dated September 12, 2018 (supplemental IME). Both were received in evidence. He testified about his findings in both IME reports.

9. Respondent was approximately 43 years old when she saw Dr. Schmitz for her IME. The specific focus of the IME was to "address allegations of postural orthostatic tachycardia syndrome [POTS] and history of intermittent syncope." POTS is a condition in which a person changing from a supine position to sitting upright or standing experiences an unusual increase in the heart's beating speed of up to 40 beats per minute, yet with no decrease in blood pressure. Symptoms associated with POTS include heart palpitations, instability, dizziness, generalized weakness, blurred vision, fainting, chest pain, exercise intolerance and fatigue. The syndrome's cause can

be post-viral, or due to an injury.[3] A "tilt table test" is used to diagnose POTS, during which the patient sits upright and is closely monitored. Intermittent syncope generally refers to a transient loss of consciousness followed by a rapid and spontaneous recovery.

10. Respondent's history of present illness began in 2012, when she was sitting at her desk at work and noticed her heart was "racing." The condition progressed to syncope and she passed out. In April 2012, she was transported by ambulance to Salinas Valley Hospital, underwent extensive evaluation including a tilt table test, and was diagnosed with POTS. She was evaluated further at Stanford University Medical Center, and is treated by a cardiologist in Fresno. Respondent has been prescribed multiple medications and was treated with multiple interventions for her condition, and, at one point, she was also referred to a psychiatrist. Her last syncopal episode was one week prior to the IME.

11. Dr. Schmitz reviewed respondent's past medical history and noted she suffered from POTS, and chronic migraine headaches. She takes multiple medications for these conditions as well as for intermittent diarrhea. Regarding daily living, she has difficulty standing, sitting, squatting, walking, and climbing stairs for long periods of time. She has difficulty grasping, gripping, lifting, and carrying. She has trouble riding and driving because she cannot sit for long periods of time. Other activities are normal, including bending, stooping, reaching, kneeling, balancing, pushing and pulling. Her physical examination results were within normal limits.

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[3] Respondent believes that the mononucleosis she suffered from during high school may be the viral infection that is the root cause of her POTS.

12. Dr. Schmitz also reviewed medical records to obtain a history of diagnoses and treatment. His notes regarding those records, which almost invariably involve symptoms of tachycardia (rapid heartbeat that may be regular or irregular, but is out of proportion to age and level of exertion or activity), are extensive and summarized as follows.

13. On March 5, 2013, Robert Collins, M.D., CHMP, saw respondent in the emergency room for chest pain and rapid heart rate, multiple episodes of which dated back to Thanksgiving of the previous year. An echocardiogram and Holter monitor were "fairly unrevealing." Respondent had a recurrence of symptoms and presented again at the E.R. later that day, complaining of chest pain and feeling like she was "going to pass out." Her diagnosis was tachycardia, shortness of breath, and chest pain. A further impression was: probable paroxysmal supraventricular tachycardia. Lopressor was prescribed.

On May 1, 2013, Robert Wlodarczyk, D.O., reported respondent had a loss-of-consciousness episode, falling and hitting her head. Respondent reported multiple such episodes. Her diagnosis was syncope, most likely orthostatic hypotension, possibly with supraventricular tachycardia. Respondent demonstrated tachycardia at rest during the hospitalization.

On May 3, 2013, James Guetzkow, M.D., diagnosed respondent with POTS, a history of supraventricular tachycardia, exercise induced asthma, shortness of breath, chest pressure, and near syncope. On May 9, 2013, Dr. Wlodarczyk treated respondent while she was hospitalized, for continuous chest pain and fatigue, and diagnosed her again with POTS. Respondent's records show she had 10 more medical visits during 2013, all for POTS-related symptoms and episodes of syncope.

14. Respondent's records show six more medical visits during 2014, involving episodes of dizziness, giddiness, chest pain, headaches, syncope and collapse. Multiple medical professionals recommended and administered various medications and treatments for respondent's condition, and cardiac devices were employed. On October 5, 2016, Melvin Helm, M.D., a neurologist, noted respondent suffered from chronic migraine headaches and significant anxiety, for which he prescribed Klonopin. Occipital nerve blocks were performed in late October 2016 to provide relief. On November 21, 2016, John Thampi, M.D., an electrophysiologist and cardiologist, noted that a 24 hour Holter monitor (placed to measure respondent's heartbeat) was "normal in variant."

15. On January 19, 2017, Dr. Thampi saw respondent and diagnosed her with POTS and migraine headaches. Respondent's records showed eight more visits, primarily with Dr. Helm for treatment of migraine headaches, and with Dr. Thampi to monitor her cardiovascular condition. On September 8, 2017, Dr. Helm reported that respondent recently saw Dr. Miglis at Stanford, and "reportedly" had a tilt table test "that suggested POTS has improved." However, on October 12, 2017, Dr. Helm reported respondent was having more severe headaches, difficulty sleeping, neck pain, and "more variation in heart rate." An appointment with a cardiologist was scheduled for the next week. On October 17, 2017, Dr. Thampi saw respondent and diagnosed her with POTS and migraine headaches.

16. No further treatment records for respondent were provided to Dr. Schmitz. His diagnosis of respondent was:

> 1. Postural orthostatic tachycardia syndrome with recurring syncope.

2. Underlying anxiety order that is exacerbated by [diagnosis number] 1.

3. Migraine headaches.

17. In his original IME, Dr. Schmitz concluded by reiterating the specific questions CalPERS set out in its retention letter instructing him to perform the reevaluation of respondent. Following each CalPERS question, he provided his answer as follows.

> [Question] 1. Based on your objective findings, are there specific job duties that you feel the member is unable to perform due to her postural [sic] and history of occasional loss of consciousness conditions? If so, please explain in detail.
>
> [Answer to Question 1:] I reviewed the applicant's job summary and discussed this carefully with her. She notes that she did return to work in 2012 even after significant accommodations, which included allowing her to go to her car and rest. In spite of these, she was not able to complete her job. The specific activities, which she is not able to engage in are being at her desk for extended periods or being in the upright position for extended periods of time. Even in those circumstances when she was given accommodations to go to her car and lie down, she could still not function.

[Question] 2. In your professional opinion, is the member presently, substantially incapacitated for the performance of her duties? Please explain in detail. Please refer to the attachment section titled *Medical Qualifications for Disability Requirement.* If incapacitated, is the incapacity permanent or temporary?

[Answer to Question 2:] It is my professional opinion that the applicant is disabled and not able to accomplish her jobs as stated. Because of her concern for syncope, she is barely able to leave her house now. It is my professional opinion that this is probably permanent although there is a possibility with medical therapy that she could improve at some point in the future. She has been tried on multiple different medications without significant improvement.

[Question] 3. Is the member cooperating with the examination and putting forth her best effort, or do you feel [*sic*] . . . .[4]

[Answer to Question 3:] I opine with reasonable medical probability that the applicant's symptoms as described are true and correct to the best of her knowledge. My opinion is also based on the review of multiple prior physician

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[4] The remaining text of the third question was omitted from CalPERS' retention letter.

reports including those at Stanford University Medical Center.

CALPERS' RESPONSE TO ORIGINAL IME

18. On August 15, 2018, Lawrence Gong, a Program Analyst in CalPERS' Disability Retirement section, wrote a letter to Dr. Schmitz seeking "clarification" of Dr. Schmitz's opinions. Rather than asking for further clarification, Mr. Gong directly contradicted Dr. Schmitz's findings and conclusions:

> Upon reviewing your report it seems that there is no compromise in postural orthostatic tachycardia syndrome and normal objective findings. It doesn't appear there are sufficient objective findings to support the retiree's subjective complaints. Yet, you opine the retiree is substantially incapacitated and provide an assortment of work preclusions.
>
> Your opinion should be based on objective findings and not subjective complaints. Based on the CalPERS Medical Qualifications for a Continuing Disability Retirement (copy attached), a retiree must have "an actual and present (not prospective) inability to substantially perform the retiree's actual and usual job duties. Furthermore, prophylactic restrictions are not a basis for a disability retirement. If a disability is not currently present but just may occur in the future, the retiree is presently ineligible for a CalPERS disability retirement."

The letter further directed Dr. Schmitz to perform another review of respondent's physical examination findings and job duties, and directed him to answer essentially the same questions he previously answered in his original IME. Mr. Gong reminded Dr. Schmitz that in accordance with his IME Agreement with CalPERS, his report must answer each specific question posed in CalPERS' initial retention letter (i.e., the questions Dr. Schmitz reproduced verbatim along with his answers). Mr. Gong then issued a warning:

> Failure to provide a complete report may result in delay of payment and possible removal of your name from the approved list of CalPERS IME list of physicians.

SUPPLEMENTAL IME

19. In response to Mr. Gong's request, Dr. Schmitz provided a Supplemental Report IME. Whereas his original IME report was 15 pages long, the Supplemental IME contained only three pages. Dr. Schmitz quickly concluded that respondent is not presently substantially incapacitated from her job duties. He noted a handful of points derived from the same medical records he extensively reviewed the month before, as "salient features" leading to his opposite conclusion. Those points include: an April 30, 2013 hospital admission following a syncopal episode; a May 2, 2013 tilt table test report consistent with a diagnosis of POTS; a May 30, 2013 evaluation by Dr. Friday at Stanford, which Dr. Schmitz questions as unclear as to whether respondent "ever saw this physician;" a September 19, 2013 tilt table test the results of which were questioned by Thomas Leonard, M.D., as being doubtful for POTS; records that Dr. Thampi followed respondent on various dates since October 2016, making several attempts to administer multiple medications; a November 2016 Holter monitor which did not detect significant arrhythmias and tachycardia; an August 2017 normal stress

test; and a September 2017 neurologist note from Dr. Helm reiterating that the patient reported she had a recent tilt table test showing improvement in POTS. Dr. Schmitz concluded he found no "recent" objective evidence of postural tachycardia.

20. At hearing, Dr. Schmitz stated his changed opinion was due to certain of respondent's more recent medical records not including objective findings to substantiate a POTS diagnosis. However, he did not explain why, having reviewed the same records prior to writing his original IME, he made no mention in the original IME of any of these "salient features" set forth in his Supplemental IME. Dr. Schmitz opined that the prognosis for POTS sufferers is typically "very good," and that 50 percent of such patients are asymptomatic within one year of diagnosis; but he offered no such prognosis for respondent, whom he considered a reliable reporter of her symptoms.

Dr. Schmitz admitted he did not know what Dr. Helm's September 2017 note meant when it stated Dr. Helm heard a recent tilt table test showed improvement in POTS, nor did he read the actual test results. He criticized his own previous reliance on respondent's statement that she could not leave the house due to her fear of recurrent syncope, because this was respondent's "subjective" statement and was not objective evidence of POTS. Although he noted Dr. Thampi's efforts to alleviate respondent's POTS symptoms with various medications, he admitted that he speculated, in his Supplemental IME, that Dr. Thampi's consultations with respondent led to improvements in her condition. He broadly explained his abrupt change of opinion between the Original IME and the Supplemental IME by stating, "I made a mistake."

Respondent's Evidence

21. Respondent began working for CDCR in 1995, enjoyed her work, and was an exemplary employee. In 2011, she went through a divorce, and when, in 2012, she

noticed her heart began "acting up," she thought the cause was stress from the divorce. The situation worsened when respondent passed out and was taken by ambulance to a hospital, where she stayed for four days. She was first treated for a "seizure," but was later diagnosed with POTS. Respondent's treating physician, Dr. Wlodarczyk, placed her off work due to POTS, but she wanted to return to her job and "begged" him to allow her to return. However, on one visit to Dr. Wlodarczyk, she passed out in his office. Still desiring to return to work, respondent went to Dr. Friday for a second opinion, but Dr. Friday's diagnosis was POTS. Respondent also saw Dr. Miglis at Stanford; Dr. Miglis's diagnosed her with POTS. Respondent continued passing out due to intermittent spikes in her heart rate, and her parents moved in with her because she could not cook or clean.

22. Respondent considers herself to be "in denial" because "I still want to work." Despite this desire, she still experiences episodes of syncope in which her heart rate goes up and down rapidly. Respondent described herself as being "very independent" and has had difficulty adjusting to being on disability. Her current physician, Dr. Thampi, monitors her medications to help manage her symptoms, and respondent hopes "for a cure" for her POTS. Her heart medications include Metoprolol 50 mg, Corlanor 5 mg, and Fludrodortisone, which Dr. Thampi prescribed. She is also prescribed Clorestamine 4 mg packets, Buspirone 10 mg, Rabeprazole 20 mg, Dicyclomene 20 mg, and Myrbetriq 50 mg for stomach problems, anxiety, and other symptoms, and receives Aimovig shots for migraines. Despite her desire to resume her job, Dr. Thampi has not approved her to return to work.

23. Based on the years of treatment she has received for POTS, respondent has learned that it is not merely a cardiovascular heart condition, as CalPERS

categorized it for purposes of her disability retirement. Instead, POTS causes several symptoms that affect other parts of her body.

24. Raymond Lares is respondent's boyfriend and has lived together with her for approximately four and one-half years. He explained that respondent still wants to return to work, but she still has episodes in which she becomes weak and "passes out," experiencing tiredness and drowsiness after she recovers. Respondent nearly always stays at home due to her condition, and is constantly tired.

Discussion

25. The burden of proof flows from the type of process initiated and lies with the party making the charges. (*Martin v. State Personnel Board* (1972) 26 Cal.App.3d 573, 582.) Respondent has been receiving industrial disability retirement benefits since December 2014. CalPERS filed this Accusation to compel her involuntary reinstatement from disability retirement. As such, the burden rests with CalPERS to prove its contentions based on competent medical evidence by a preponderance of the evidence. CalPERS did not meet its burden.

26. Most of the evidence in this matter is undisputed. CalPERS was within its rights to reevaluate respondent. Dr. Schmitz, a board-certified expert, was qualified to perform the evaluation on CalPERS' behalf. He performed an original IME in standard fashion, gathering a history and background information, reviewing medical records covering several years of care and treatment, interviewing and examining respondent, and formulating a three-part diagnosis. He then produced a detailed, thorough original IME report in which he offered his opinions and findings related to each specific question CalPERS directed him to answer. CalPERS reacted to the original IME with a letter to Dr. Schmitz plainly rejecting his opinions and conclusions, demanding

that he write a second report, and raising the specter of retribution in the form of non-payment and his removal from CalPERS' list of approved IME experts if he failed to comply with CalPERS' demands. The letter's author, Mr. Gong, identified himself as a program analyst in a disability review unit; thus, a reasonable presumption may be made that he is not a physician. CalPERS routinely forwards additional medical evidence to its expert as a basis for requesting a supplemental expert opinion; but here, no such additional evidence was provided. Despite receiving no further evidence, Dr. Schmitz changed his opinion, repudiating the findings he made in his 15-page original IME with a three-page response covering far less information and analysis.

27. Dr. Schmitz was an earnest but uneasy witness. His discomfort was understandable, as his testimony essentially served to undermine his own credibility. His revised conclusion was based solely on the notion that no "objective" evidence supported respondent's current disability. Yet this conclusion overlooked a substantial, undisputed fact: multiple physicians have continued to diagnose respondent as suffering from POTS. Business and Professions Code section 2038 provides:

> Whenever the words "diagnose" or "diagnosis" are used in this chapter, they include any undertaking by any method, device, or procedure whatsoever, and whether gratuitous or not, to ascertain or establish whether a person is suffering from any physical or mental disorder. Such terms shall also include the taking of a person's blood pressure and the use of mechanical devices or machines for the purpose of making a diagnosis and representing to such person any conclusion regarding his or her physical or mental condition. . . .

Despite one physician expressing doubt about respondent's POTS diagnosis in September 2013, virtually every other doctor who consulted with or treated respondent from May 2013 until October 2017 – the most recent records CalPERS relied on in its review – rendered a diagnosis of POTS. In addition, Dr. Schmitz diagnosed respondent with POTS as part of his original IME process, and did not alter his diagnosis in his Supplemental IME. This is evidence that these physicians ascertained or established that respondent continued to suffer from POTS. At hearing, CalPERS presented no evidence to establish otherwise.

28. Any argument that a physician's medical diagnosis should be discounted as "subjective" must fail, as the basic process of modern medical practice relies primarily upon the formal assessment a physician renders based on the best available patient information at hand. The diagnosis is a fundamental starting point, and provides justification for the subsequent treatment a physician orders.

29. In this case, complainant's assessment of objective-versus-subjective evidence either supporting or refuting respondent's disability was jumbled. For example, Dr. Schmitz pointed out that Dr. Thampi has continued to administer medications to alleviate respondent's POTS condition. In his Supplemental IME, Dr. Schmitz noted this as presumably objective evidence that showed respondent was getting better (and, hence, was no longer disabled). Yet respondent, who still desires to return to work, credibly testified that she continues to suffer from intermittent syncope and other POTS-related symptoms, and she cannot persuade Dr. Thampi to

approve her return to work.[5] One could argue that since respondent is reporting her condition, this is subjective evidence only and should be discounted. Then, at hearing, Dr. Schmitz admitted that he did not know whether the multiple medications Dr. Thampi continued to try on respondent were actually improving her condition or symptoms; this opinion does not distinguish objective-versus-subjective evidence. In addition, the medical record establishes Dr. Thampi's continuing diagnosis of POTS and continuing prescribing to alleviate POTS. This is objective evidence supporting respondent's testimony. In sum, none of the distinctions between objective-versus-subjective evidence serve to clarify the issue of whether respondent is still disabled.

30. Evidence Code section 780, subdivision (b), provides that the court may consider in determining the credibility of a witness the character of his testimony. Here, despite Dr. Schmitz's credentials and apparent sincerity, the character of his testimony was ineffective and not persuasive, as his turnabout came across as a capitulation rather than a measured reassessment. This left CalPERS well short of proving the allegations in the Accusation by even a preponderance of the evidence. For all these reasons, the Accusation must be dismissed.

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[5] Respondent provided a letter from Dr. Thampi, dated August 26, 2019, stating she is unable to return to work until (at least) February 2, 2020. The letter was received as administrative hearsay pursuant to Government Code section 11513, subdivision (d).

LEGAL CONCLUSIONS

1. By reason of her employment, respondent is a state industrial member of CalPERS and eligible for disability retirement under Government Code section 21151, subdivision (a).

2. The burden of proof flows from the type of process initiated and lies with the party making the charges. (*Id*, at p. 582.) Respondent has been receiving industrial disability retirement benefits since approximately January 2014. CalPERS filed this Accusation to compel her involuntary reinstatement from disability retirement, so the burden rests upon CalPERS to prove its contentions based on competent medical evidence by a preponderance of the evidence.

3. The Board "may require any recipient of a disability retirement allowance under the minimum age for voluntary retirement for service applicable to members of his or her class to undergo medical examination, and upon his or her application for reinstatement, shall cause a medical examination to be made of the recipient who is at least six months less than the age of compulsory retirement for service applicable to members of the class or category in which it is proposed to employ him or her." (Gov. Code, § 21192.)

4. "If the determination pursuant to Section 21192 is that the recipient is not so incapacitated for duty in the position held when retired for disability or in a position in the same classification or in the position with regard to which he or she has applied for reinstatement and his or her employer offers to reinstate that employee, his or her disability retirement allowance shall be canceled immediately, and he or she shall become a member of this system. If the recipient was an employee of the state or of the university and is so determined to be not incapacitated for duty in the position

held when retired for disability or in a position in the same class, he or she shall be reinstated, at his or her option, to that position . . . " (Gov. Code, § 21193.)

5. The role of disability retirement is to address the needs of employees who are unable to work because of a medical disability. (Gov. Code, § 21153.) Pursuant to Government Code section 21192:

[W]hile termination of an unwilling employee for cause results in a complete severance of the employer-employee relationship [citation], disability retirement laws contemplate the potential reinstatement of that relationship if the employee recovers and no longer is disabled. Until an employee on disability retirement reaches the age of voluntary retirement, an employer may require the employee to undergo a medical examination to determine whether the disability continues.

An employee on disability retirement may apply for reinstatement on the ground of recovery. (*Ibid.*) If an employee on disability retirement is found not to be disabled any longer, the employer may reinstate the employee, and his disability allowance terminates. (Gov. Code, § 21193.) (*Haywood v. American Fire Protection Dist.* (1998) 67 Cal.App.4th 1292, 1305.)

6. CalPERS did not meet its burden of proving by competent medical evidence that respondent is no longer substantially disabled for performance of her duties as an AGPA at Correctional Training Facility. For the reasons set forth in Findings 25 through 30, Dr. Schmitz's revised opinion that respondent is not substantially incapacitated for performance of her usual job duties as a CO was not compelling or persuasive.

ORDER

Respondent's appeal is SUSTAINED and the Accusation is DENIED. Respondent's disability retirement shall remain intact.

DATE: October 8, 2019

DocuSigned by:
John DeCure
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JOHN E. DeCURE

Administrative Law Judge

Office of Administrative Hearings