

**ATTACHMENT A**

**THE PROPOSED DECISION**

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

**In the Matter of the Statement of Issues against:**

**CHRISTIAN A. LADD and DEPARTMENT OF FISH AND  
WILDLIFE, Respondents**

**Case No. 2019-0085**

**OAH No. 2019040433**

**PROPOSED DECISION**

Tiffany L. King, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on September 26 and December 19, 2019, in Sacramento, California

Helen Louie, Staff Counsel, represented the California Public Employees' Retirement System (CalPERS).

Charles N. Malmsten, Attorney at Law, represented Christian A. Ladd (respondent).

Catherine Kennedy, Senior Staff Counsel, represented respondent California Department of Fish & Wildlife (CDFW).

CALIFORNIA PUBLIC EMPLOYEES'  
RETIREMENT SYSTEM

FILED January 22 20 20

JEH

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on December 19, 2019.

## **ISSUE**

At the time CDFW filed an employer-originated disability retirement application on his behalf, was respondent substantially incapacitated from the performance of his duties as an Information Technology Specialist I on the basis of a gastrointestinal (cirrhosis) condition?

## **FACTUAL FINDINGS**

1. Respondent was employed by CDFW from July 2006 to October 1, 2018. The last job position he held was as an Information Technology (IT) Specialist I. By virtue of his employment, respondent is a state miscellaneous member of CalPERS pursuant to Government Code<sup>1</sup> section 21150. Respondent has the minimum service credit necessary to qualify for retirement.

2. On April 6, 2018, CDFW signed an application for disability retirement on behalf of respondent, and requested CalPERS determine whether respondent was substantially incapacitated from the performance of his duties. In the application, CDFW listed the following conditions as the basis for the disability claim: hepatitis C,

---

<sup>1</sup> All further statutory references are to the Government Code, unless otherwise specified.

cirrhosis of the liver, jaundice ecchymosis, peripheral edema, tremor, and history of bleeding esophageal varices.

3. By letters dated April 11, 2018, and May 7, 2018, CalPERS requested respondent file an application for disability retirement and provide medical reports for CalPERS's review. On May 11, 2018, respondent signed an application for an employer-originated disability retirement. In the application, respondent asserted he had no medical limitations or preclusions due to his "gastro internal" condition.

4. By letter dated August 3, 2018, CalPERS informed respondent that the employer-originated disability retirement application was approved, and that respondent was deemed to be substantially incapacitated from the performance of his usual duties as an IT Specialist I. The letter advised respondent of his right to appeal CalPERS's determination, which he did. This hearing followed.

### **Respondent's Employment with CDFW**

5. Respondent was hired as an IT Specialist I by CDFW in July 2006. His last duty statement, signed on April 13, 2017, lists the following essential functions for his position: help desk support (40%) and computer technical support (45%). The statement also lists other administrative duties (15%) as nonessential functions of the position. Under working conditions, the duty statement provides: using a keyboard for several hours a day; operating various IT equipment on daily basis; sitting most of the time, but some walking or standing for brief periods of time; and, occasionally moving equipment with a maximum weight limit of 50 pounds (individually) or 100 pounds (with another person).

6. Respondent explained his duties primarily included answering customer calls, troubleshooting over the telephone and by remotely accessing the user's

computer, installing software, and cleaning viruses. Occasionally, he was required to conduct on-site visits to work on a user's computer, or to disconnect, relocate, and reconnect a computer or other equipment when an employee was hired, moved offices, or made other changes. This sometimes required respondent to crawl under a desk to disconnect cables or wires; however, respondent was never required to physically move a desk or other large furniture.

7. The IT department conducts an annual "refresh", whereby it replaces or updates approximately 20 percent of the computers (between 500 and 700) for CDFW's more than 3,500 employees. During "refresh," IT employees receive the new equipment at headquarters, perform an inventory, and move the equipment by cart to a service room where it is stored until ready for deployment. Approximately half of CDFW employees use a desktop computer with a tower that weighs between 10 and 25 pounds. The other half utilize a laptop computer, weighing between two and 10 pounds. Additionally, printers may be replaced during a "refresh." Large printers are freestanding on the floor and have wheels at their base for transport. Mid-sized network printers weigh between 60 and 70 pounds, and are transported by placing them on a cart. Finally, small desktop printers may be transported by placing them on a cart or hand-carrying them to their new location.

8. In late 2015, respondent underwent endoscopic surgery which resulted in internal bleeding. Around the same time, he was also diagnosed with cirrhosis of the liver associated with the virus hepatitis C, which respondent had contracted from a blood transfusion he received at age 6. The virus had remained dormant until respondent began experiencing symptoms as an adult.

9. Respondent's primary physician referred him to a gastroenterologist, Nazir Rahim, M.D., for treatment and management of hepatitis C, and cirrhosis of the

liver complicated by "ascites, hepatic encephalopathy, and history or esophageal variceal bleeding." Dr. Rahim prescribed Harvoni<sup>2</sup> with ribavirin<sup>3</sup>, which caused respondent to experience side effects including extreme fatigue, anemia, nausea, and other gastrointestinal symptoms. Accordingly, Dr. Rahim placed respondent on light duty (no more than 25 hours per week) beginning June 20, 2016, and through November 1, 2016. Initially, the Harvoni therapy appeared to be successful and respondent's viral load for hepatitis C dropped considerably. However, in 2017, his viral load rebounded to a detectable level. Respondent began a new round of medical therapy, comprised of a 24-week regimen of Epclusa<sup>4</sup> with ribavirin. During this time, respondent's light duty was extended multiple times and his restrictions were as follows: no lifting more than 15 pounds and no working more than 25 hours per week.

10. By letter dated January 29, 2018, Dr. Rahim again modified respondent's work restrictions to no lifting more than 20 pounds and no working more than 30 hours per week. In his letter, Dr. Rahim advised CDFW that respondent's medical therapy was tentatively expected to end on May 23, 2018.

11. Thereafter, on January 31, 2018, CDFW ordered respondent to undergo a fitness for duty (FFD) evaluation with Scott T. Anderson, M.D. The FFD evaluation took

---

<sup>2</sup> Harvoni is a brand name for a combination of the antiviral medications, ledipasvir and sofosbuvir.

<sup>3</sup> Ribavirin is an antiviral medication used in combination with other medications to treat hepatitis C.

<sup>4</sup> Epclusa is a brand name for a combination of medications, sofosbuvir and velpatasvir.

place on February 9, 2018. Following the evaluation, Dr. Anderson opined that respondent was not fit for duty and was substantially incapacitated from the performance of his usual duties as an IT Specialist. Dr. Anderson's findings and opinions are discussed in greater detail below.

12. By letter dated March 15, 2018, CDFW notified respondent of its intent to apply for disability retirement on respondent's behalf and its placement of respondent on involuntary leave pending CalPERS's determination.

13. On March 21, 2018, Dr. Rahim submitted a letter to CDFW which responded to Dr. Anderson's findings from the FFD evaluation and CDFW's placement of respondent on involuntary leave. In his letter, Dr. Rahim opined that respondent's "overall liver condition [had] significantly improved," and that respondent was able to resume his prior job duties. In a letter to CDFW dated April 13, 2018, Dr. Rahim reiterated that respondent's condition had stabilized and that he "can return to regular work duty . . . [and] is able to resume full time work without limitations on May 3, 2018."<sup>5</sup>

14. Respondent did not return to work at CDFW after being placed on involuntarily leave. Since then, he has found work through different temporary placement agencies. Since December 2018, he has worked part-time as a driver for Sherwin Williams, where he also performs some IT work. As a driver, he is responsible

---

<sup>5</sup> At hearing, Dr. Rahim explained that respondent's Eplclusa treatment was scheduled to end in May 2018, which is why he listed this date. However, he confirmed his initial opinion that respondent was able to return to full duty without restrictions as of March 21, 2018.

for picking up and delivering one-gallon cans and five-gallon buckets of paint weighing 50 or more pounds. He has had no difficulty lifting this weight by himself.

15. Respondent desires to return to work at CDFW. He has felt ready and able to perform his usual duties as an IT Specialist I, including lifting of 50 pounds by himself, since at least April 5, 2018, when CDFW filed a disability retirement application on his behalf.

### **Expert Testimony**

#### **SCOTT T. ANDERSON, M.D.**

16. CDFW retained Scott T. Anderson, M.D., Ph.D., to conduct an Independent Medical Evaluation (IME) and Fitness for Duty Evaluation (FFD) of respondent. Dr. Anderson is a Clinical Professor of Medicine at the University of California, Davis, Division of Rheumatology, Allergy, and Clinical Immunology with training and experience in the diagnosis and treatment of rheumatologic conditions. He is certified by the American Board of Internal Medicine in Internal Medicine, Rheumatology, and Geriatric Medicine. Dr. Anderson has performed medical evaluations for a variety of entities, including CalPERS, the Workers' Compensation Appeals Board, and private disability insurance providers. He is also an expert consultant for the Medical Board of California.

17. On February 9, 2018, Dr. Anderson performed an IME and FFD of respondent to "determine if any condition identified during [the] evaluation may affect [respondent's] ability to perform the essential duties of his permanent full-time position." Dr. Anderson prepared an initial and supplemental report of his findings, dated February 9, 2018, and April 20, 2018, respectively; he testified at hearing regarding the same.

18. As part of his evaluation, Dr. Anderson reviewed respondent's work history, duty statement, history of present illness, and medical records, and performed a physical examination. At the time of the IME, respondent's work restrictions included working no more than 25 hours per week and no lifting of more than 15 pounds.

19. Respondent reported that he contracted hepatitis C in childhood after he underwent a blood transfusion at age 6. The virus was dormant for several years. As an adult, he was diagnosed with cirrhosis of the liver associated with hepatitis C. He was hospitalized for a hernia in 2015, and internal bleeding following endoscopy in 2016. His current medications include Epclusa, ribavirin, amlodipine, nadolol, pravastatin, and furosemide.

20. At the IME, respondent presented with the following symptoms: muscle cramps, muscle pain, muscle shrinkage, joint pain and stiffness, joint swelling, chronic fatigue, excessive drowsiness, trouble sleeping, and easy bruising. After the physical examination, Dr. Anderson noted respondent had "trace yellow discoloration of the sclerae<sup>6</sup> consistent with jaundice." He also noted the following diagnoses: hepatitis C, cirrhosis, jaundice, edema, ecchymosis, tremor, and esophageal varices. These conditions, Dr. Anderson explained, interfere with respondent's ability to perform his duties "by inhibiting his physical ability of bending, squatting, lifting, as well as inhibiting his endurance, and potentially inhibiting his ability to perform fine motor acts due to the associated tremor that can occur with end-stage liver disease."

---

<sup>6</sup> The sclera (plural – sclerae) is the white outer layer of the eyeball.  
(<https://www.merriam-webster.com/dictionary/sclera#medicalDictionary>)

Additionally, respondent's "generally debilitated physical status . . . would interfere with his ability to perform the above-described job duties."

21. Dr. Anderson opined that respondent was not fit for duty as of the date of the IME. He explained,

. . . The reason is that [respondent] has a chronic life-threatening condition that renders him fatigued, weak and at risk for complications for many mild injuries such as contusion as well at risk for life-threatening hemorrhage if he performs heavy lifting which might put strain upon his varices. Continuing to work therefore would put him at risk for life-threatening complications. Moreover, the overall debility which he experiences would render him unable to perform a complete workday of laborious activities such as described in the Duty Statement. Specifically, he cannot perform the lifting activity of 50 pounds occasionally. He could not crawl around or behind computers, bend and squat repeatedly or could he respond to large volume of calls due to his generally debilitated condition.

22. Dr. Anderson further opined that respondent's condition is permanent, noting: "His liver has been damaged by hepatitis C. Even if the virus is eradicated with current therapy, he will have the chronic sequelae of cirrhosis as outlined under diagnoses."

23. At hearing, Dr. Anderson expanded on his findings. Regarding hepatitis C, he acknowledged that treatments developed over the last decade, including

Harvoni, have brought the cure rate up to 90 percent. However, he cautioned that a lack of longitudinal data does not inform on what happens to these patients after 10 or 20 years, and whether the virus will relapse. Regarding cirrhosis, Dr. Anderson explained that this occurs when normal tissue in the liver is replaced with scar tissue. As this occurs, the liver swells, then shrinks and contracts. Over time, the liver can lose its ability to function. Cirrhosis condition can cause death or result in a patient living with a chronic illness. In Dr. Anderson's experience, a cirrhosis condition does not improve even when the causative factor (here, hepatitis C) is removed. He continued that, due to respondent's history of bleeding varices, any strenuous maneuver, such as using abdominal muscles, puts pressure on his varices and increases the risk of a catastrophic hemorrhage. Based on these factors, Dr. Anderson confirmed his opinion that respondent was substantially incapacitated from the performance of his duties as an IT specialist.

**NAZIR RAHIM, M.D.**

24. Respondent called Nazir Rahim, M.D., as an expert witness. Dr. Rahim is the Medical Director and Staff Gastroenterologist at the Folsom Sierra Endoscopy Center. He is certified by the American Board of Internal Medicine in Gastroenterology. Dr. Rahim began treating respondent in October 2015, upon the referral of respondent's primary care physician for treatment of his hepatitis C and esophageal varices, and management of cirrhosis complicated by ascites and hepatic encephalopathy.

25. To treat the hepatitis C, Dr. Rahim began respondent on a regimen of Harvoni with ribavirin in June 2016. After beginning Harvoni treatments in June 2016, respondent suffered various side effects, namely extreme fatigue, anemia, nausea, and other gastrointestinal symptoms. The treatment was initially successful. However, in

early 2017, the virus reappeared. Dr. Rahim prescribed a new regimen of Epclusa with ribavirin for 24 weeks. Dr. Rahim noted that there are no governing guidelines concerning work restrictions while taking Epclusa. Rather, job restrictions, if any, are determined on a case-by-case basis.

26. While respondent was on Epclusa, Dr. Rahim closely monitored his hepatitis C viral load, blood counts, liver function, and kidney function. After the first six to eight weeks of treatment, the hepatitis C viral load was "undetectable." After the treatment was complete, the viral load remained undetectable. Additionally, respondent's liver and kidney functions, as well as blood count, remained stable both during and post treatment.

27. Dr. Rahim again evaluated respondent on March 16, 2018, toward the end of respondent's Epclusa treatment. In his March 21, 2018 letter to CDFW regarding this visit, Dr. Rahim noted the following regarding respondent's conditions:

Regarding [respondent's] ascites, it has significantly resolved with use of diuretics (his most recent abdominal scan also confirmed no further ascites). In addition, his hepatic encephalopathy is well-controlled with lactulose and Xifaxan . . . . I did not appreciate any signs of active encephalopathy (i.e., confusion, disorientation). Lastly, his most recent upper endoscopy revealed significant diminished esophageal varices not requiring band ligation, which significantly reduces his risk of bleeding. He also seems to have more energy and is less fatigued likely due to suppression of his hepatitis C virus (undetectable recent viral load).

Dr. Rahim concluded the letter: "Therefore, as his treating physician who has seen his overall condition improve and stabilize, it is my assessment that [respondent's] liver condition has significantly improved as reflected by his recent labs, scans, and overall clinical condition (i.e., no further decompensation). I feel without hesitation that he can adequately resume his prior job duties."

28. Dr. Rahim reviewed Dr. Anderson's FFD and IME reports. He disagreed with Dr. Anderson's conclusion that respondent was not fit for duty, pointing out that Dr. Anderson "had not appreciated [respondent's] improvement in his medical, and specifically, liver conditions." Dr. Rahim explained that respondent was far more decompensated when he first began treating him in 2015, but that his condition had significantly improved in the years since.

29. Dr. Rahim also disagreed with Dr. Anderson's finding that respondent should refrain from bending, squatting, or lifting because these activities could potentially cause a life-threatening bleeding incident based on respondent's history of esophageal varices. Dr. Rahim noted that variceal or internal veins do not pose this significant risk, and that Dr. Anderson's opinion deviates from the standard recommendation. Regarding Dr. Anderson's findings based on suspected jaundice, Dr. Rahim noted that the liver condition cannot be adequately assessed by the appearance of jaundice alone, and that laboratory tests would be required to determine the liver condition accurately. In any event, Dr. Rahim noted that discoloration of the eye could be related to respondent's treatment, is not life-threatening, and does not pose a risk of causing life-threatening bleeding.

30. Dr. Rahim further disagreed that respondent was unfit for duty, or substantially incapacitated from the performance of his usual duties, on the basis of his cirrhosis condition. He explained that cirrhosis is a condition with varying severities,

and that while it can be managed and controlled, the condition is never "cured." A patient with significantly decompensated cirrhosis may require hospitalization in an intensive care unit. Once the condition has compensated, the patient will still carry a cirrhosis diagnosis, but will be ambulatory and mobile. Dr. Rahim analogized respondent's cirrhosis diagnosis to that of another chronic condition, high blood pressure. He explained that a patient with high blood pressure would not be restricted from work solely on the potential that strenuous activity could lead to a stroke. In this case, Dr. Rahim determined respondent's cirrhosis and overall liver condition were sufficiently stable that he could return to his usual duties without restriction. At hearing, he reiterated that opinion "without hesitation."

**MICHAEL BRONSHVAG, M.D.**

31. CalPERS called Michael Bronshvag, M.D., as its expert witness, having previously retained him to conduct an IME of respondent. Dr. Bronshvag is an Assistant Clinical Professor of Occupational Medicine at the University of California, San Francisco. He is certified by the American Board of Internal Medicine in Internal Medicine. Dr. Bronshvag has performed IMEs on behalf of CalPERS and is familiar with the CalPERS's standard for disability retirement.

32. On July 9, 2018, Dr. Bronshvag performed an IME of respondent. As part of the evaluation, Dr. Bronshvag reviewed respondent's medical history and records, and conducted a physical examination. He wrote an initial and supplemental report, dated July 9, 2018, and July 13, 2018, respectively, regarding his findings. He testified at hearing consistent with the same.

33. Respondent reported he took Harvoni with ribavirin to treat his hepatitis C, which worked temporarily, and that he had just finished a course of a newer

medicine, Epclusa with ribavirin. He has a history of liver disease and gastroesophageal varices, but otherwise his review of symptoms is "quite unremarkable." He was hospitalized in 2016 due to internal bleeding related to treatment of the varices. Regarding his employment as IT Specialist I, respondent reported he "very seldom has to actually lift anything, although he will have to – every now and then – reach under a desk to find a USB port." Respondent reported that he plays golf every day and builds fences.

34. Dr. Bronshvag noted that respondent's platelet count was "a little bit low" and his bilirubin was "modestly elevated." He reviewed Dr. Anderson's reports and medical records from Dr. Rahim, noting their difference of opinion. Dr. Bronshvag performed his own physical examination of respondent. He found no evidence of encephalopathy, hepatic or otherwise.<sup>7</sup> Pulse and blood pressure were normal. There was no demonstrable jaundice, and his eyes, funduscopic examination, and cranial nerves were normal. Musculoskeletal exam was normal and no gross sensory or motor neurological deficits were present.

35. Dr. Bronshvag diagnosed respondent as having hepatitis C with complication of cirrhosis, varices, and ascites, though he noted that respondent was negative for the hepatitis C virus at the time of the IME. Additionally, while Dr. Bronshvag confirmed the presence of structural abnormality of liver disease (cirrhosis), he commented that respondent did not have varices at that time.

---

<sup>7</sup> Hepatic encephalopathy is defined as "a decline in brain function that occurs as a result of severe liver disease." (<https://www.healthline.com/health/hepatic-encephalopathy-2>)

36. Dr. Bronshvag confirmed that respondent could “keel over” on the job at any time. However, he noted respondent could also keel over on the golf course or while building a fence, and that barring any heavy lifting, respondent would be safer at work than on the golf course or building fences. In his initial report, Dr. Bronshvag did not definitely opine whether there were any specific job duties which respondent was unable to perform at the time of the IME. He noted that respondent should not do “substantive amounts of lifting, or efforts in awkward positions (crawling around under desks, etc.)” He further opined that, as of the date of the IME, respondent was able to return to work half-time, and that his ability to return to work full-time should be reevaluated in three months.

37. In his supplemental report, Dr. Bronshvag clarified that respondent could not lift 50 pounds on his own on a full-time basis and on demand. He further stated that respondent was substantially incapacitated from performing his usual duties as a IT Specialist I based on “the nature of physical requirements, and the medical information provided re the series of events relevant to his liver and treatments initially unsuccessful, and now apparently successful for the last month or so – but with no guarantee of continued success of the treatments.” Finally, Dr. Bronshvag opined that respondent’s incapacity would last for “another six to 12 months.”

## **Discussion**

38. Respondent appealed from CalPERS’s approval of the employer-originated disability retirement based on its determination that respondent was substantially incapacitated from the performance of his usual duties as an IT Specialist I, as of the date of filing, or April 6, 2018. Respondent’s personal gastroenterologist, Dr. Rahim, opined that he was substantially capable of performing his usual duties as of March 21, 2018. Drs. Anderson and Bronshvag reached the opposite conclusion.

Specifically, they found respondent to be substantially incapacitated on the basis that his duty statement requires he be able to lift up to 50 pounds on his own, and up to 100 pounds with another person.

39. Dr. Rahim's testimony was persuasive. He has been treating respondent for hepatitis C and management of cirrhosis and other associated conditions since 2015, and personally observed the significant improvements made to respondent's condition. Respondent's viral load for hepatitis C has been "undetectable" since 2017. His liver and kidney functions, as well as his blood count, have remained stable since that time. While respondent may never fully eradicate his cirrhosis condition, the severity of his condition has vastly improved since beginning treatment in 2016, and there was no medical evidence offered that his condition will decompensate to an incapacitating level in the future. Dr. Rahim's findings and opinion were further bolstered by the fact that respondent has regularly engaged in activities (golf and building fences) and carrying of five-gallon paint buckets, weighing 50 pounds or greater, without any difficulty since being placed on leave involuntarily.

40. Drs. Anderson's and Bronshvag's findings of substantial incapacity focus mainly on the fact that respondent may be called to lift up to 50 pounds on his own, that his previous workplace restrictions prohibited from lifting more than 30 pounds, and that such a strenuous activity *may* result in catastrophic internal bleeding as a result of respondent's cirrhosis and history of bleeding esophageal varices. First, the existence of physician-imposed workplace restrictions does not necessarily equate to substantial incapacity to perform one's usual job duties. For example, workplace restrictions and limitations are frequently imposed through the workers' compensation process, but do not necessarily result in a conclusion that the employee is substantially incapacitated for purposes of a CalPERS's disability retirement.

41. Second, Drs. Anderson and Bronshvag's concerns that a requirement that respondent lift up to 50 pounds *may* result in his "keeling over" or catastrophic internal bleeding were not based on events certain or even likely to happen, but appeared more prophylactic in nature which are insufficient to support a finding of substantial incapacity for purposes of disability retirement. (See *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, 863 [prophylactic restrictions imposed to prevent the risk of future injury or harm are insufficient to support a finding of disability; a disability must be currently existing and not prospective in nature].) Indeed, in his initial report, Dr. Bronshvag suggested that respondent's regular activities of playing golf and building fences posed to be a greater risk than performing his job as an IT Specialist I.

42. Finally, for purposes of disability retirement, "incapacitated for the performance of duty" means the "*substantial* inability of the applicant to perform his usual duties." (*Mansperger v. Public Employees' Retirement System (Mansperger)* (1970) 6 Cal.App.3d 873, 875 [italics in original].) The inability to perform some of the duties of a position does not render one disabled. (*Mansperger, 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 a task without help from others was a remote occurrence].) Here, the evidence established that respondent was required to lift and move IT equipment on an occasional basis only; even then, he was rarely required to lift anything on his own which weighed more than a 25-pound desktop tower. Thus, even assuming respondent could not lift up to 50 pounds on his own, this restriction by itself does not render him substantially incapacitated.

43. When all of the evidence is considered, respondent established that he was not substantially incapacitated from the performance of his duties as an IT

Specialist I as of the filing date of the employer-originated disability retirement application. His appeal from CalPERS's determination to the contrary must therefore be granted.

## LEGAL CONCLUSIONS

1. "As in ordinary civil actions, the party asserting the affirmative in an administrative hearing has the burden of proof going forward and the burden of persuasion by a preponderance of the evidence." (*McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051.) Here, respondent has appealed from CalPERS's determination that he is substantially incapacitated from the performance of his usual duties as an IT Specialist I. Therefore, he bears the burden of proving that he was capable of substantially performing the usual duties of his job at the time CDFW filed the disability application on his behalf.

2. Section 21150, subdivision (a), provides, in pertinent part, that "[a] member incapacitated for the performance of duty shall be retired for disability pursuant to this chapter if he or she is credited with five years of state service, regardless of age . . . ."

3. As defined in 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.

4. Section 21152 provides that an application for disability retirement may be made by:

(a) The head of the office or department in which the member is or was last employed, if the member is a state member other than a university member.

[¶] . . . [¶]

(c) The governing body, or an official designated by the governing body, of the contracting agency, if the member is an employee of a contracting agency.

(d) The member or any person in his or her behalf.

5. Section 21153, provides, in relevant part, that “an employer may not separate because of disability a member otherwise eligible to retire for disability but shall apply for disability retirement of any member believed to be disabled, unless the member waives the right to retire for disability and elects to withdraw contributions or to permit contributions to remain in the fund with rights to service retirement as provided in Section 20731.”

6. Section 21154 states:

The application shall be made only (a) while the member is in state service, or . . . (c) within four months after the discontinuance of the state service of the member, or while on an approved leave of absence, or (d) while the member is physically or mentally incapacitated to perform duties from the date of discontinuance of state service to the time

of application or motion. On receipt of an application for disability retirement of a member, . . . the board shall, or of its own motion it may, order a medical examination of a member who is otherwise eligible to retire for disability to determine whether the member is incapacitated for the performance of duty . . . .

7. Section 21156, subdivision (a)(1) states:

If the medical examination and other available information show to the satisfaction of the board, or in case of a local safety member, other than a school safety member, the governing body of the contracting agency employing the member, 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 . . . .

8. “‘Disability’ and ‘incapacity for performance of duty’ as a basis of retirement, mean disability of permanent or extended and uncertain duration, which is expected to last at least 12 consecutive months or will result in death, as determined by the board . . . on the basis of competent medical opinion.” (§ 20026.) “We hold that to be ‘incapacitated for the performance of duty’ within section 21022 means the substantial inability of the applicant to perform his usual duties.” (*Mansperger, supra*, 6 Cal.App.3d at 876.) *Mansperger* continues to be the definitive statement of California courts to date regarding the meaning of the language of section 21156 “incapacitated for the performance of duty,” in the context of an application for a disability

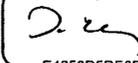
retirement. The inability to perform some of the duties of a position does not render one disabled. (*Mansperger, supra*, at pp. 876-877.)

9. As set forth in the Factual Findings as whole, and in particular Factual Findings 38 through 42, respondent established by competent medical evidence that he was capable of substantially performing his usual duties as an IT Specialist I as of April 6, 2018. His appeal from CalPERS's determination of substantial incapacity must therefore be granted.

### ORDER

Respondent Christian A. Ladd's appeal from CalPERS's determination of substantial incapacity, and approval of the employer-originated disability application based thereon, is GRANTED.

DATE: January 22, 2020

DocuSigned by:  
  
E4650D5DE8FE46C...

TIFFANY L. KING

Administrative Law Judge

Office of Administrative Hearings