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:

MARIAN HUSTED and

DEPARTMENT OF STATE HOSPITALS, COALINGA SECURE TREATMENT FACILITY, Respondents.

Case No. 2019-1193

OAH No. 2020030058

PROPOSED DECISION

Marcie Larson, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by telephone and video conference on April 15 and May 26, 2021, in Sacramento, California.

Austa Wakily, Senior Attorney, appeared on behalf of the California Public Employees' Retirement System (CalPERS).

Danny T. Polhamus, Attorney at Law, represented respondent Marian Husted, who was present.

There was no appearance by or on behalf of respondent Department of State Hospitals, Coalinga Secure Treatment Facility (Department). The Department was duly served with a Notice of Hearing. The matter proceeded as a default against the Department pursuant to California Government Code section 11520, subdivision (a).

Evidence was received, and the record was held open until July 14, 2021, for the submission of closing and reply briefs. CalPERS's closing brief was marked as Exhibit 16 and reply brief was marked as Exhibit 17. Respondent's closing brief was marked as Exhibit FFFF and Reply Brief was marked was Exhibit GGGG. The the record was closed, and the matter was submitted for decision on July 14, 2021.

ISSUE

The issue on appeal is whether, at the time respondent filed her application for industrial disability retirement on the basis of a pulmonary/internal condition (Valley Fever), respondent was substantially incapacitated from the performance of her usual and customary duties as a Supervising Rehabilitation Therapist (Supervising Therapist) for the Department?

FACTUAL FINDINGS

Procedural History

1. In 2007, respondent was employed by the Department as a Rehabilitation Therapist. In 2013, she was promoted to Supervising Therapist. On June 5, 2019, respondent signed and thereafter filed an application for service retirement pending industrial disability retirement (application) with CalPERS. By virtue of her employment,

respondent is a state safety member of CalPERS subject to Government Code section 21151.

2. In filing the application, respondent claimed disability on the basis of "Valley fever." Respondent wrote that the condition occurred on August 6, 2013, from "work site exposure." Respondent further wrote that due to her condition she had "nausea, headaches, joint pain, enlarged heart, high blood pressure, diarrhea, exhaustion, shortness of breath, on oxygen."

3. CalPERS obtained medical records and reports, including reports prepared by Karthikeya Devireddy, M.D., Elizabeth Vogler, M.D., Richard Prier, M.D., Tiffany Tayler, M.D. and Thomas Leonard, M.D., who conducted an Independent Medical Evaluation (IME) of respondent concerning her Valley Fever. After reviewing the reports, CalPERS determined that respondent was not substantially incapacitated from the performance of her job duties as a Supervising Therapist for the Department.

4. On October 30, 2019, CalPERS notified respondent that her application for industrial disability retirement was denied. CalPERS advised respondent of her appeal rights. She timely filed an appeal and request for hearing.

5. On or about February 10, 2020, Keith Riddle, Chief, Disability and Survivor Benefits Division, Board of Administration, CalPERS, signed and thereafter filed the Statement of Issues. The matter was set for an evidentiary hearing before an Administrative Law Judge of the OAH, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

Respondent's Duties as a Supervising Rehabilitation Therapist

6. As set forth in the Duty Statement, a Supervising Therapist in respondent's position was required to "plan, direct and supervise personnel of the Rehabilitation Therapy" of the Department and to also "coordinate Rehabilitation Therapy activities with other interdisciplinary services of the facility, perform Rehabilitation Therapy work and do other related work."

7. On May 17, 2019, respondent signed a "Physical Requirements of Position/Occupational Title" form (Physical Requirements form). On October 17, 2019, a Return-to-Work Coordinator for the Department also signed the Physical Requirements form. The Physical Requirements form was submitted to CalPERS. According to the Physical Requirements form, when working as a Supervising Therapist respondent: (1) constantly (over 6 hours) sat and used a keyboard and mouse; (2) frequently (three to six hours a day) twisted her neck and waist, reached above and below the shoulders, engaged in simple grasping, and repetitively used her hands; (3) occasionally (up to three hours), sat, stood, ran, kneeled, squatted, bent at the neck and waist, pushed and pulled, engaged in fine manipulation and power grasping, lifted or carried between 0 and 50 pounds, walked on uneven ground, was exposed to dust, gas, fumes, or chemicals, operated foot controls or repetitive movement, and worked with bio hazards; (4) never crawled, climbed, lifted or carried more than 51 pounds, drove, worked with heavy equipment, was exposed to excessive noise, or extreme temperature, humidity or wetness, worked at heights or used special visual or auditory protective equipment.

Respondent's History of Injury

8. In 2009, respondent developed double pneumonia, which she believes was caused by Valley Fever she was exposed to at the Department. However, no testing ever confirmed her belief. She was first diagnosed with Valley Fever after exposure on August 6, 2013. On that day, respondent stepped outside of the Department's building. The wind was blowing. She was hit in the face with dirt and debris. A few days after the incident, she began to feel tired during the day. She fell asleep at her desk. She also developed a rash on her back.

On December 20, 2013, respondent saw a nurse practitioner at her local clinic and requested to be tested for coccidioidomycoses, also referred to as Valley Fever. Respondent was aware that people living in the Central Valley of California can contract Valley Fever due to the dry, windy, and dusty conditions that can spread Valley Fever spores. On December 20, 2013, respondent was diagnosed with Valley Fever.

9. From 2013 until 2018 respondent continued to work for the Department. However, her symptoms continued. She had difficulty breathing, suffered from joint pain, rashes, night sweats, coughing, headaches, exhaustion, and vision disturbance. She also developed a lesion in the right upper lobe of her lung, which was confirmed from a CT scan. In 2018, respondent's shortness of breath prevented her from walking more than five to ten minutes. In the spring of 2018, she was diagnosed with tachycardia. She attributes all her symptoms to Valley Fever, which she believes has disseminated into her organs.

10. On November 23, 2018, respondent stopped working for the Department because she could "no longer breathe," lift more than 10 pounds, or complete her job

duties. Respondent was also exposed to dirt and dust each day she reported to work. Respondent believes the continued exposure to dust contributed to her ongoing symptoms.

11. Respondent filed a workers compensation claim for her Valley Fever condition. She was evaluated by Qualified Medical Examiner Scott Anderson, M.D., for her workers' compensation claim. Respondent was also treated by an infectious disease specialist in California from 2014 until 2018. In July 2019, respondent moved to Washington because she believed the change of weather would help her condition. Respondent sought treatment with several doctors including Kimberly Dougan, M.D., and Jason Simmons, M.D., Ph.D.

Respondent's Medical Evidence

12. In support of her application, respondent submitted hundreds of pages of medical records and reports. Respondent had breast cancer 30 years ago, which was treated with a stem cell transplant and reconstructive surgery. Since 2013, respondent treated with several physician's including Richard Prier at the Prier Medical Clinic. Additionally, Dr. Dougan and Dr. Simmons testified at hearing concerning their treatment and evaluation of respondent.

INITIAL DIAGNOSIS AND SUBSEQUENT TREATMENT

13. On December 20, 2013, respondent was seen at the Coalinga Regional Medical Center. She complained of having extreme exhaustion, fatigue, and a rash on her back for three to four weeks. She requested at "cocci serology" to test for Valley Fever, because she had "recently been exposed to ground-breaking construction at work." The lab results test for coccidioides antibody with a titer level of 1:16, which was flagged as "high." The number on the right side of the colon mark is the number that

can correlate to higher disease activity or dissemination of the infection into other organs. Within a month of the diagnosis, respondent was prescribed antifungal medication used to treat Valley Fever. Respondent filed a workers' compensation claim and was off work for several months.

14. Between December 2013 and August 2014, respondent was treated by Revnaldo Cordero, M.D., and Atsuko Rees, M.D. Respondent was diagnosed with a three-centimeter cavitary lung lesion, likely caused by Valley Fever. In approximately August 2014, respondent began seeing Richard Prier, M.D. Dr. Prier performed an evaluation and ordered laboratory testing. The September 2, 2014 laboratory testing found that respondent's coccidioides antibody titer level was 1:8. The results also noted that there was "no significant change in the coccidioidal complemental fixation titer since Feb[uary] 2014." Dr. Prier did not prescribe respondent any medication to treat Valley Fever.

15. In November 2014, July 2015, and April 2016, Dr. Prier ordered updated laboratory testing for respondent to monitor her coccidioides antibody titers level. The results in November 2014 and July 2015, found that respondent's coccidioides antibody titer level was 1:8. The April 2016 results found that respondent's coccidioides antibody titer level was 1:16.

16. Laboratory testing to monitor respondent's coccidioides antibody titer level in early 2018 also found that respondent's coccidioides antibody titer level was 1:16. Dr. Prier placed respondent on anti-fungal medication to treat her Valley Fever infection. He also noted that she was using oxygen at night. By February 2018, her coccidioides antibody titer level was 1:32. Respondent was still complaining of fatigue and periodic rashes. Dr. Prier ordered additional testing to determine if respondent had autoimmune issues or other medical issues. In 2018, respondent was also

diagnosed with tachycardia, which is an irregular heartbeat. No treatment was given to respondent for the condition.

17. In October 2018, Dr. Prier ordered updated laboratory testing that found respondent's coccidioides antibody titer level was 1:64. Dr. Prier again prescribed anti-fungal medication to treat her Valley Fever. On November 29, 2018, Dr. Prier took respondent off work for 60 days due to her "illness and side effects of treatment." Respondent did not return to work.

18. In February through May 2019, updated laboratory testing found that respondent's coccidioides antibody titer level was still 1:64. However, Dr. Prier did not prescribe any treatment for the Valley Fever. Throughout Dr. Prier's treatment of respondent, he also ordered C-reactive protein and sedimentation rate testing which detect for active disease. These tests were consistently normal.

19. In July 2019, respondent moved to Washington and began treatment with several physicians including Dr. Simmons and Dr. Dougan.

TESTIMONY AND RECORDS FROM JASON SIMMONS, M.D., PH.D.

20. Dr. Simmons is licensed to practice medicine in Washington State. He is a diplomate of the American Board of Internal Medicine and holds an Infectious Diseases Certification from the Board of Internal Medicine. Dr. Simmons is an attending physician and works in the infectious disease clinic at the Harborview Medical Center (Harborview) in Seattle, Washington.

21. In late 2019 or 2020, Dr. Simmons met respondent when her pulmonary doctor referred her to determine whether respondent needed treatment for Valley Fever. Dr. Simmons explained that Valley Fever can be confirmed through a blood test

and laboratory testing referred to as complement fixation titer, which measures the level of disease activity. For example, 1:16 is a titer result from a low amount of antibody compared to a titer of 1:32 or 1:64, which would be a higher titer.

22. Dr. Simmons explained that his first visit with respondent included an extensive review of her records, an account of her current and previous symptoms, and a physical examination. Respondent reported that she was not experiencing any flare-ups at that time. Dr. Simmons determined that her breathing was normal and she had no abnormal lung sounds. Her heart rate was normal and he found no swelling in her joints. He found no evidence of an active Valley Fever infection.

Dr. Simmons ordered a CT scan of respondent's lungs to confirm the prior diagnosis of a cavitary lung lesion and determine if there was any increase in the size. There was not. Dr. Simmons also opined that the cavity or hole in her right lung is likely a result of Valley Fever. He explained that this type of lung cavity is associated with Valley Fever. A pulmonary function test was also ordered. Dr. Simmons explained that the results were that respondent did not have "much in the way of obstruction, but she had a mild restrictive lung disease." This means the lungs were not able to expand as effectively as a "normal lung," which can contribute to shortness of breath.

Dr. Simmons reviewed respondent's laboratory testing history and saw that her titer levels have fluctuated since she was initially diagnosed with Valley Fever in 2013. Initially her titer was 1:16. Respondent was treated with an antifungal therapy and her titer level dropped to 1:8. However, over time her titer levels have increased to as high as 1:64.

23. Dr. Simmons explained that 90 percent of Valley Fever diagnoses are "uncomplicated," which means that the patients may or may not have symptoms.

Patients with high titer levels can also have no symptoms. If a patient develops symptoms, they will typically develop pneumonia. The immune system fights the infection and it clears. However, some individuals have chronic infection that can be limited to the lungs. Even fewer individuals are unable to fight the infection and it spreads to other tissues and organs. This is referred to dissemination. Some people are prescribed antifungal medication to treat the condition. Respondent was treated with antifungal medication but she suffered from side effects.

24. After the initial appointment in January 2020, Dr. Simmons emailed George Thompson, M.D., at the University of California, Davis Medical Center (UC Davis). Dr. Thompson is national expert in treating Valley Fever. Dr. Simmons explained that Dr. Thompson and UC Davis had extensive experience treating patients with high titer levels including up to 1:256, yet there was no finding that dissemination had occurred. Dr. Simmons consulted with Dr. Thompson on whether respondent should be treated with antifungals, despite her titer levels having fluctuated around 1:32. Dr. Thompson informed Dr. Simmons that respondent did not need to start antifungals based on her titer.

25. Dr. Simmons continues to treat respondent. Respondent's most recent titer results in the summer of 2020 was 1:32. Dr. Simmons explained that respondent has complained of joint pain and headaches that limit her ability to work and function. Dr. Simmons opined that these could be "flare ups" which are a result of disseminated Valley Fever. However, disseminated Valley Fever is typically confirmed through an invasive procedure to remove tissue from an infected area. No such procedure has been performed on respondent. Dr. Simmons also explained that he could not opine whether respondent's tachycardia was caused by Valley Fever unless a biopsy of the

heart tissue was conducted to test for the presence of the organism in the actual tissue.

TESTIMONY AND RECORDS FROM KIMBERLY DOUGAN, M.D.

26. Dr. Dougan has been a practicing physician since 2008. Dr. Dougan first met respondent on February 20, 2020. Respondent's specialist at Harborview recommended respondent see a primary care doctor near her home to treat conditions such as her persistent her cough, shortness of breath, and chronic fatigue. Dr. Dougan had never treated a patient with Valley Fever. Respondent's physicians at Harborview continued to treat respondent's Valley Fever. Dr. Dougan explained she is treating the "whole patient."

27. Dr. Dougan's initial examination of respondent included taking a lengthy history and review of records. Respondent informed Dr. Dougan that she continued to have symptoms from her chronic Valley Fever, including rashes, cough, shortness of breath, low-grade fevers, fatigue, joint pain, chronic inflammation and poor sleep. Dr. Dougan also conducted a physical examination, which included listening to respondent's lungs. Dr. Dougan found that respondent had "decreased breath sounds" but otherwise the examination findings were normal. Dr. Dougan also ordered a comprehensive metabolic panel, which was normal other than a slightly low potassium level. Respondent had also recently had a scan conducted that showed a renal mass that was found to be cancer.

28. Dr. Dougan has continued to treat respondent since February 2020. She last saw respondent in January 2021. However, all visits since the initial visit have been through telemedicine due to the pandemic. Respondent had a kidney removed as a result of her cancer. No testing was performed to determine if the cancer was caused

by Valley Fever. Respondent has continued to complain of the same symptoms she attributes to Valley Fever.

29. Dr. Dougan reviewed the Physical Requirements for respondent's position as a Supervising Therapist. Dr. Dougan opined that respondent is not able to return to work or perform many of the job duties due to her Valley Fever condition. Specifically, respondent cannot walk for more than one mile without resting. She cannot lift anything that weighs more than five pounds. Dr. Dougan also opined that exposure to dust and dirt would make her symptoms worse. Dr. Dougan also opined that kneeling and going up and down stairs or ladders would be detrimental to her health, and possibly exacerbate her symptoms. Respondent could also not jump or climb. Respondent cannot be exposed to dust, gas, fumes, or chemicals up to three hours a day because of her lung condition.

QME REPORT

30. On March 13, 2020, Dr. Anderson conducted a Qualified Medical Re-evaluation of respondent related to her workers' compensation claim and issued a report. Dr. Anderson had previously evaluated respondent and issued reports dated April 23 and June 15, 2015.

31. Dr. Anderson's evaluation included obtaining occupational history, chief complaint, history of present illness, medical history, review symptoms, record review, and physical examination. Respondent reported that her chief complaint was "'spots in other lung...spots on kidney.'" Respondent reported that she "disseminated" Valley Fever dating back to August 6, 2013. Respondent's present complaint was also arthralgias in her knees, feet and hands, which is joint pain. Respondent also complained of "cardiac problems manifesting with arrhythmia." Dr. Anderson noted

that respondent's arrhythmia had been "largely in the form of palpitations or possible transient episodes of tachycardia."

Respondent also reported headaches and "mild difficulty with gait associated with mild unsteadiness while ambulating." Respondent reported that she is able to drive, walk, cook, clean, and shop, but she limits her physical exercise. She also could perform "bending, stooping, walking and sitting." However, she "cannot perform climbing or lifting due to pain." She cannot walk more than one mile unless she rests along the way. Respondent reported she could not lift more than 10 pounds.

32. Dr. Anderson completed a physician examination. When examining respondent's lung, he found she had a "mild decrease in air entry noted at apices." Dr. Anderson did not find any "overt synovial inflammation" in respondent's hands, feet, ankles, and knees, which he found to have full range of motion. Dr. Anderson noted that respondent's gait was "somewhat unsteady."

33. Dr. Anderson rendered several diagnoses all of which he attributed to Valley Fever, including:

1. Coccidioidomycosis, status post cavitary pneumonia of lungs.

2. Intermittent tachycardia due to coccidioidomycosis.

3. Polyarthralgia due to coccidioidomycosis.

4. Tension headaches due to coccidioidomycosis.

5. Ataxia with gait abnormality due to coccidioidomycosis.

6. Insomnia due to coccidioidomycosis.

34. Dr. Anderson opined that respondent would be "significantly challenged in returning to gainful employment." He further opined that respondent's "physical manifestations of her chronic coccidioidomycosis include shortness of breath, palpitations, malaise, fatigue, difficulty sleeping, [and] joint pain." Dr. Anderson also opined that respondent could not perform the essential duties of her job, but if she were to return to work, she would need to be in a "temperature-controlled air-conditioned environment" and need "disability parking" to address her shortness of breath and heart condition. She would also need a four-hour day or 20-hour week due to her "lack of physical stamina." She would not be able to use staircases, work at heights greater than three feet, or lift more than five pounds.

Independent Medical Evaluation by Thomas Leonard, M.D.

35. On September 9, 2019, at CalPERS's request, Dr. Leonard conducted an IME of respondent. Dr. Leonard prepared an initial report and three supplemental reports. He testified at the hearing consistent with his reports.

36. Dr. Leonard is board-certified in Internal Medicine. In 1967, he graduated with his medical degree from New York Medical College. He completed an internship in San Francisco at the United States Public Health Service. From 1969 through 1973, he completed his residency at the Public Health Service at University of California, San Francisco, which included a one-year fellowship in cardiopulmonary disease. From 1973 until 1984, Dr. Leonard started and managed a new critical care unit in Vallejo General Hospital. From 1973 until 1996, Dr. Leonard operated a private practice. He has treated many patients with Valley Fever. Since 1993, he has been performing medical evaluations related to respiratory illnesses including Valley Fever.

37. As part of the IME, Dr. Leonard interviewed respondent, obtained a medical history, and conducted a physical examination. He also reviewed the Physical Requirements form, duty statement for respondent's position and respondent's medical records.

RESPONDENT'S COMPLAINTS

38. Dr. Leonard obtained a history of respondent's condition and her present complaints. Respondent informed Dr. Leonard that in 2009, she became ill after being exposed to dust. She developed a cough and fever. She tested negative for coccidioidomycoses. In 2013, she was exposed to a "blast of dust or dirt and became ill, developed a rash on her back and in fact fainted when at her keyboard." She was treated by Dr. Prier who prescribed antifungal medication for nine months, which improved her titer levels from 1:16 to 1:8.

39. Respondent also reported that starting approximately a year before in the spring, she developed a headache and irregular heartbeat, which her cardiologist attributed to her lung disease and reduced oxygenation. She also continued to see Dr. Prier intermittently, who continued to treat her with antifungal medication, but she could no longer tolerate the medication. Respondent explained that she and Dr. Prier believe she has disseminated Valley Fever due to the rise of her titer level to 1:64.

40. Respondent stated her symptoms include shortness of breath, wheezing, discomfort in her joints, reduced energy, chronic and constant headaches, and difficulty sitting and walking. Dr. Prier also prescribed respondent oxygen at night after a sleep study was performed in March 2018 that showed respondent had reduced oxygen levels at night when sleeping.

PHYSICAL EXAMINATION AND REVIEW OF RECORDS

41. Dr. Leonard completed a physical examination of respondent, which included a review of systems and taking respondent's blood pressure and pulse. He examined her eyes, nose, throat, and torso. He also listened to her heart and lungs. Respondent's vital signs were normal. Respondent appeared to be comfortable and had no difficulty rising from a chair without support. She was able to ambulate without difficulties. Respondent's lungs were generally clear. Dr. Leonard did hear an "occasional high-pitched expiratory wheeze," which he opined is consistent with the history of having asthmatic difficulties. Respondent's heart rhythm and sound were also normal. Respondent had no skin rashes or skin abnormalities

42. Dr. Leonard also reviewed respondent's medical records, including diagnostic and laboratory reports. Dr. Leonard explained that when a patient is diagnosed with Valley Fever, it is common to test for and follow the complement fixation titers, which is considered to be a marker of level of activity of the disease. Dr. Leonard explained that in some instances a high titer can be concerning because the organism may be disseminating out of the lungs into other tissues.

Respondent's titer levels vacillated from 1:8 up to 1:64. Dr. Leonard opined that a titer level of 1:64 is not evidence of dissemination. Dr. Leonard explained that Dr. Prier looked for other measures of activity of disease such as a C-reactive protein and the sedimentation rate, which measures the activity of disease. Both tests were normal. He explained that if respondent had active disease activity, these tests would be abnormal.

43. Dr. Leonard also opined that the imaging studies of respondent's lung cavity did not suggest a worsening infection. Rather the results were consistent with a finding that her lung cavity was stable.

DIAGNOSIS AND OPINIONS

44. Dr. Leonard opined there is no evidence that respondent suffers from disseminated Valley Fever. Dr. Leonard found no evidence of dissemination during his physical examination of respondent. Additionally, while respondent's complement fixation titer level has been as high as 1:64, which could imply dissemination, respondent's C-reactive protein and sedimentation rate were normal, which support his finding that there is no dissemination or active inflammatory process. Dr. Leonard opined that respondent is not substantially incapacitated from performing her job duties due to Valley Fever.

45. Additionally, Dr. Leonard opined respondent does not have an "actual or present pulmonary impairment that rises to the level of substantial incapacity to perform her usual job duties." Dr. Leonard explained that the imaging studies of respondent's lungs demonstrated that respondent had some "fibrotic disease from the pneumonia, but otherwise she has been stable and most probably not oxygen dependent." Dr. Leonard noted that he did not have records related to pulmonary studies obtained that may provide additional information regarding her lung capacity.

SUPPLEMENTAL REPORTS

46. On June 10, 2020, August 3, 2020, and April 9, 2021, Dr. Leonard issued supplemental IME reports after reviewing additional medical records CalPERS provided to him. The June 10, 2020 supplemental IME report addresses Dr. Anderson's March 13, 2020 QME report. Dr. Leonard opined that Dr. Anderson's report lacked "objective

data to support his opinions, and therefore, his examination, if anything, supports all of the opinions that I have expressed in the past." Dr. Leonard did not change his opinions as a result of reviewing Dr. Anderson's report.

47. Dr. Leonard's August 3, 2020 supplemental IME report addresses a report written by Dr. Anderson in 2015, a pulmonary functions study obtained in 2015, and additional treatment records. Dr. Leonard noted that the pulmonary function study "showed that the vital capacity was only minimally reduced." He further opined that "[t]he flow rates were also minimally reduced but she did have a reduced total lung capacity and diffusion abnormalities." Dr. Leonard opined that the findings were "consistent or in concert with the findings of x-ray having some linear or fibrotic like changes." Dr. Leonard did not change his opinions as a result of reviewing the additional records.

48. Dr. Leonard's April 9, 2021 supplement IME report addresses additional medical records from various treatment providers, including Dr. Simmons and Dr. Dougan. Based on review of the records, Dr. Leonard opined there is no evidence of dissemination of Valley Fever, or that respondent is substantially incapacitated from the performance of her duties as a Supervising Therapist due to Valley Fever.

Analysis

49. When all the evidence is considered, respondent failed to establish that at the time she filed her application she was permanently disabled or substantially incapacitated from performing the usual duties of a Supervising Therapist for the Department, due to her Valley Fever condition. Respondent was diagnosed with Valley Fever in December 2013. She continued to work for the Department until November

2018, periodically receiving treatment for her condition. Respondent reported improvement in her condition after treatment.

50. Although respondent has presented evidence of subjective complaints including, fatigue, headaches, shortness of breath, and joint pains, Dr. Leonard's opinion that the the objective evidence does not support a finding that respondent is substantially incapacitated from the performance of her duties due to Valley Fever is most persuasive. Dr. Leonard conducted a physical examination and reviewed respondent's extensive medical records. The evaluation and records support Dr. Leonard's opinion that respondent does not have disseminated Valley Fever. The studies performed also did not provide any objective evidence that respondent is not able to perform her job duties due to Valley Fever.

51. Additionally, neither Dr. Simmons nor Dr. Dougan provided any opinions supported by objective findings to demonstrate respondent is substantially incapacitated from the performance of her job duties as a Supervising Therapist. Dr. Simmons opined that disseminated Valley Fever could only be confirmed by an invasive procedure which has not been performed on respondent. Dr. Dougan opined that respondent would not be able to perform the physical requirements of her job due to fatigue and shortness of breath. Respondent's fatigue is a subjective complaint. The pulmonary function study, an objective test, demonstrated that her lung capacity was minimally reduced, which Dr. Leonard explained would not limit her ability to perform her job duties.

52. Furthermore, Dr. Anderson did not make a finding as to whether respondent is substantially incapacitated from the performance of her duties. Rather, he opined that based in part on respondent's reported symptoms, returning to work would be difficult. He recommended prophylactic restrictions to address her subjective

complaints. Dr. Anderson did not testify at hearing and was not available for cross-examination. As a result, his opinions were admitted only as administrative hearsay and cannot be relied upon, standing alone, to support any findings as to respondent's condition. (Gov. Code, § 11513, subd. (d).)

53. Respondent did not present competent medical evidence to support the assertion that at the time she filed her application she was permanently disabled or substantially incapacitated from the performance of her usual and customary duties as a Supervising Therapist based upon the legal criteria applicable in this matter. Consequently, respondent failed to establish that her application should be granted based upon her Valley Fever condition.

LEGAL CONCLUSIONS

1. Respondent seeks disability retirement pursuant to Government Code section 21151, subdivision (a), which provides in pertinent part, that "[a]ny patrol, state safety, state industrial, state peace officer/firefighter, or local safety member incapacitated for the performance of duty as the result of an industrial disability shall be retired for disability, pursuant to this chapter, regardless of age or amount of service."

2. To qualify for disability retirement, respondent must prove that, at the time she applied, she was "incapacitated physically or mentally for the performance of [her] duties...." (Gov. Code, § 21156, subd. (a)(1).) Government Code section 20026 defines "disability" and "incapacity for performance of duty," as follows:

> "Disability" and "incapacity for performance of duty" as a basis of retirement, mean disability of permanent or

> extended duration, which is expected to last at least 12 consecutive months or will result in death, as determined by the board, or in the case of a local safety member by the governing body of the contracting agency employing the member, on the basis of competent medical opinion.

3. In *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876, the court interpreted the term "incapacity for performance of duty" as used in Government Code section 20026 (formerly section 21022) to mean "the *substantial* inability of the applicant to perform his usual duties." (Emphasis in original.)

4. In *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 855, the court explained that prophylactic restrictions that are imposed to prevent the risk of future injury or harm are not sufficient to support a finding of disability; a disability must be currently existing and not prospective in nature. The applicant in *Hosford* had suffered injuries to his left ankle and knee and had strained his back. The court noted that the sergeant "could sit for long periods of time but it would 'probably bother his back;' that he could run but not very adequately and that he would probably limp if he had to run because he had a bad ankle; that he could apprehend persons escaping on foot over rough terrain or around and over obstacles but he would have difficulty and he might hurt his back; and that he could make physical effort from the sedentary state but he would have to limber up a bit." (*Id.* at p. 862.) Following *Mansperger*, the court in Hosford found that the sergeant:

> ... is not disabled unless he is substantially unable to perform the usual duties of the job. The fact that sitting for long periods of time in a patrol car would "probably hurt his

> back," does not mean that in fact he cannot so sit; ...[¶] As for the more strenuous activities, [a doctor] testified that Hosford could run, and could apprehend a person escaping over rough terrain. Physical abilities differ, even for officers without previous injuries. The rarity of the necessity for such strenuous activity, coupled with the fact that Hosford could actually perform the function, renders [the doctor's conclusion that Hosford was not disabled] well within reason. (*Ibid.*)

In *Hosford*, the sergeant argued that his condition increased his chances for further injury. The court rejected this argument, explaining that "this assertion does little more than demonstrate that his claimed disability is only prospective (and speculative), not presently existing." (*Hosford v. Board of Administration, supra*, 77 Cal.App.3d at p. 863.)

5. In *Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697, the court determined that a deputy sheriff was not permanently incapacitated for the performance of his duties, finding: "A review of the physician's reports reflects that aside from a demonstrable mild degenerative change of the lower lumbar spine at the L-5 level, the diagnosis and prognosis for the appellant's condition are dependent on his subjective symptoms." In *Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, the court found that discomfort, which may make it difficult for an employee to perform his duties, is not sufficient in itself to establish permanent incapacity. (See also, *In re Keck* (2000) CalPERS Precedential Bd. Dec. No. 00-05, pp. 12-14.)

6. The burden of proof is on respondent to demonstrate that she is substantially incapacitated from the performance of her usual and customary duties

such that she is permanently disabled. (*Harmon v. Board of Retirement of San Mateo County, 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 as a Supervising Therapist for the Department. (See *Harmon v. Board of Retirement, supra*, 62 Cal.App.3d at 697.)

7. Findings issued for the purposes of workers' compensation are not evidence that respondent's injuries are substantially incapacitating for the purposes of disability retirement. (*Smith v. City of Napa*, (2004) 120 Cal.App.4th 194, 207; *English v. Board of Administration of the Los Angeles City Employees' Retirement System* (1983) 148 Cal.App.3d 839, 844; *Bianchi v. City of San Diego*, (1989) 214 Cal.App.3d 563.)

8. When all the evidence is considered, respondent did not present competent, objective medical evidence to establish that she was substantially incapacitated from performance of her usual duties as a Supervising Therapist at the time she filed her industrial disability retirement application. Therefore, based on the Factual Findings and Legal Conclusions, respondent is not entitled to retire for industrial disability pursuant to Government Code section 21151, subdivision (a).

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ORDER

Respondent Marian Husted's application for industrial disability retirement is DENIED.

DATE: August 10, 2021

Marcie Larson
Marcie Larson (Aug 10, 2021 13:20 PDT)

MARCIE LARSON

Administrative Law Judge

Office of Administrative Hearings