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 Concerning the Application for Industrial Disability Retirement of:

ATZIRI VILLAGOMEZ, Respondent

and

CALIFORNIA INSTITUTION FOR WOMEN, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, Respondent.

Agency Case No. 2021-0138

OAH No. 2021060149

PROPOSED DECISION

Kimberly J. Belvedere, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter utilizing the Microsoft Teams application, on April 29, 2022.

Maria Christina Andrade, Staff Attorney, represented complainant, Keith Riddle, Chief, Disability and Survivor Benefits Division, Board of Administration, California Public Employees' Retirement System (CalPERS), State of California.

Thomas J. Wicke, Lewis, Marenstein, Wicke, Sherwin & Lee, LLP, represented respondent Atziri Villagomez.

There was no appearance on behalf of respondent, California Institution for Women, California Department of Corrections and Rehabilitation (CDCR).

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on April 29, 2022.

ISSUE

Did competent medical evidence establish that respondent[1] was substantially incapacitated from performing the usual and customary duties of a correctional officer for CDCR on the basis of an orthopedic condition (left knee), at the time she filed her application for industrial disability retirement on January 18, 2020?

SUMMARY OF DECISION

Respondent had the burden by a preponderance of the evidence that, at the time she filed her application for industrial disability retirement, she was substantially incapacitated from performing the usual and customary job duties of a correctional

[1] Hereinafter, the word "respondent" refers solely to Atziri Villagomez.

officer based on the claimed orthopedic condition. Although respondent credibly testified that she suffers from ongoing pain and/or discomfort at times, pain or difficulty in performing one's job is not a basis for disability retirement. Accordingly, competent medical evidence did not establish respondent was substantially incapacitated from performing the usual and customary job duties of a correctional officer, and respondent's application for an industrial disability retirement is denied.

FACTUAL FINDINGS

Jurisdictional Matters

1. Respondent commenced her employment as a correctional officer with CDCR on July 17, 2017. By virtue of her employment, respondent is a state safety member of CalPERS subject to Government Code section 21151.

2. On April 17, 2018, respondent fell at work and sustained an injury to her left knee. She sought medical treatment on that date and eventually had surgery on her left knee. She also underwent physical therapy. Respondent has not returned to work since May 2, 2017.

3. On January 18, 2020, respondent signed an application for industrial disability retirement with CalPERS. Respondent claimed a disability based on a "torn left meniscus." She did not claim any other injuries or basis for a retirement. In her application, respondent wrote:

> While working at Puerta La Cruz Conservation Camp I was unloading a delivery truck on the kitchen dock and I took a

step backwards falling 35 feet [*sic*] hitting my left knee & body on concrete.

When asked in the application what her limitations are, respondent wrote: "no running, or jumping. No kneeling or squatting. No climbing. I am unable to stand for long periods, I can't run, jump, kneel, squat, or climb due to the pain and swelling in my left knee." CalPERS construed respondent's claim of a disability broadly, and alleged it in the statement of issues as an orthopedic condition to her left knee.

4. CalPERS obtained medical records and reports related to respondent's claimed disability. CalPERS required respondent undergo an independent medical evaluation by Leisure Yu, M.D., Ph.D., on November 17, 2020. Dr. Yu concluded respondent was not substantially incapacitated from performing the usual and customary duties of a correctional officer.

5. CalPERS also reviewed medical records from Maria Bella Ramirez, M.D., William C. Holland, M.D., Keola Chun, M.D., Jonathan K. Lee, M.D., and Neil T. Katz, M.D., prior to rendering a final determination.

6. On December 17, 2020, CalPERS issued a final determination and notified respondent by letter that her application for an industrial disability retirement was denied. Respondent timely appealed that determination; this hearing ensued.

Duties of a Correctional Officer

7. Several documents were submitted that detail the physical requirements and essential functions of a correctional officer with CDCR. Those documents included: a CalPERS Form; two CDCR documents that detail the essential functions of a correctional officer; and a California Department of Human Resources document

regarding the duties and essential functions of a correctional officer. The following is a summary of the pertinent parts of those documents.

8. The CalPERS document was difficult to follow. The boxes for "never" and "constantly over six hours" were both checked for the following activities: sitting, standing, walking, kneeling, and climbing. The form reported respondent never had to run or crawl. For the activities of squatting and bending at the waist and neck, the form reported both that she both "never" and also "occasionally up to three hours" had to perform these activities. Twisting and reaching was reported as occasionally, up to three hours. Fine manipulation, power grasping, repetitive use of hands, lifting and carrying from 0 to in excess of 100 pounds, working with heavy equipment, exposure to excessive noise, operation of foot controls, list of special visual or auditory equipment, and working with biohazards, was reported as "never." Twisting at the neck and waist, reaching above and below the shoulder, simple grasping, keyboard use, and mouse use were reported as "occasionally up to 3 hours." The only duties reported solely as "constantly over six hours" were walking on uneven ground and exposure to dust, gas, fumes, or chemicals. The entries on this form were considered, but, given the contradiction in most of the entries as well as the clearly erroneous entries (most of the most basic physical activities were shown as "never"), it was not given much weight.

9. The CDCR's list of usual and customary job duties and essential functions of a correctional officer, which is a sworn peace officer position include but are not limited to the following: work in minimum and maximum security institutions; perform duties in a variety of posts; work overtime; wear personal protective equipment such as stab proof vests and breathing apparatus; qualify with firearms; swing a baton with force; defend against inmates armed with weapons; subdue inmates; apply restraints;

run occasionally in an all-out effort while responding to alarms or serious incidents; standing on uneven surfaces; climb occasionally; crawl and crouch occasionally; stand occasionally or continuously depending on assignment; and sit occasionally or continuously depending on assignment; continuously wear equipment belt weighing 15 pounds; lifting and carrying anywhere from 20 pounds to 50 pounds frequently and up to 100 pounds occasionally; physically restrain or carry an inmate occasionally; performing duties in a cramped space; pushing and pulling occasionally to frequently depending on the situation (such as opening and closing locked gates and cell doors or during restraint of an inmate); and reaching occasionally to continuously overhead during searches.

10. Some of the examples of the type of work a correctional officer may need to perform while engaging in the above physical activities include, but are not limited to: physically restraining or wrestling an inmate; lifting or carrying an inmate out of a cell; working in cramped spaces; crouching while firing a weapon; subduing an inmate; searching inmates; and use of the appropriate amount of force for various situations that arise in the correctional environment.

Respondent's Testimony

11. Respondent is 36 years old. She started her career as a correctional officer with CDCR on July 7, 2007. When she is working, her uniform consists of a tan shirt, nametag, whistle, flashlight, bullet-proof vest, baton, pepper spray, radio, personal alarm, handcuffs, personal protective gear, keys, and heavy boots. Some of these items are worn on her duty belt which she estimates is around 15 pounds when fully loaded. Handcuffs are used frequently depending on the assignment, such as, when a correctional officer is working transport. Other than transport, handcuffs are rarely used. Similarly, a weapon is only used if a correctional officer is assigned to a

gun post or transportation. Nonetheless, regardless of what position a correctional officer is assigned to, he or she must qualify with a duty weapon at the range on a quarterly basis. Her duties also include patting down inmates, crouching to perform inmate and cell searches; transporting and escorting inmates; running to an alarm when an emergency occurs; walking on uneven ground; and maneuvering stairs.

Respondent has worked in various prisons over the years. In 2015, she went to a conservation camp near Temecula. In that facility there are approximately 75 inmates that must be supervised. During a shift, there are eight correctional officers, one sergeant and a lieutenant. Respondent worked eight hour days and sometimes incurred overtime. Every three months correctional officers change shifts. Respondent performed many of the escorting and searching activities described above on a daily basis. Correctional officers must take counts of the inmates four times each day.

On April 17, 2017, respondent was working as a correctional officer. She was unloading a truck. She stepped back and fell off the dock, landing on concrete. She landed on her knees. The inmates picked her up. After being injured, she went to U.S. Healthworks in Murietta. They took an x-ray of her left knee and gave her a knee brace and a cane. The doctors there took her off work for approximately two weeks and then cleared her to go back to full-duty. Respondent returned to full duty on May 1, 2017. At first she "felt fine," but in the middle of the day she felt like she "couldn't do it anymore" as she was experiencing pain. Respondent went back to U.S. Healthworks and she was taken off work again. They gave her pain medication and ordered an MRI. Respondent was then referred to Dr. Holland. Dr. Holland performed surgery on respondent's left knee in June 2017.

Respondent claims the pain she now has is worse than before she had surgery. She has had physical therapy, acupuncture, and injections for the pain, but nothing

helps. Dr. Holland suggested that perhaps they re-open the left knee to ensure that there isn't any sharpness around the meniscus, but she is not going to have surgery again. Another doctor offered to perform a knee replacement but respondent refused because she is scared. To manage pain, she takes ibuprofen. Respondent's present symptoms include throbbing pain that is sometimes sharp. When that happens, she elevates her leg but that only helps "for a moment."

Respondent said that the reason the CalPERS form that describes essential physical functions of her job was filled out wrong was because she was in pain and did not know the significance of the form.[2]

Summary of Medical Records

12. The following is a summary of various pertinent medical records relating to respondent's left knee condition:

13. According to an MRI report dated May 16, 2017, completed by Jennifer Lin, M.D., approximately one month after respondent's fall at work, the following findings were noted:

> The medial and lateral collateral ligaments are intact
>
> The anterior and posterior cruciate ligaments are intact

[2] This was unclear because normally an employer fills out the form. Thus, it is unknown why respondent filled out the CalPERS form (and, at that, filled it out incorrectly).

> There is a small oblique tear at the posterior horn of the medial meniscus extending to the inferior articular surface. The medial compartment articular cartilage is preserved.
>
> There is mild chondral fraying at the patellar median eminence. There is no underlying bone narrow edema. The trochlear articular cartilage is preserved. The distal quadriceps and patellar tendons are intact.
>
> There is no joint effusion or loose body. There is a tiny popliteal cyst.

14. William Holland, M.D., saw respondent on June 28, 2017. Respondent's chief complaint, at that time, was that she has pain and swelling along the medial aspect of her knee when she performs certain activities. Respondent told Dr. Holland that most of the time she does "reasonably well" and is able to "stand and walk" but was unable to do her job. Respondent denied any locking or instability. Dr. Holland examined respondent's left knee and found:

> Examination of the left knee reveals no swelling or effusion. Her motion was from full extension to 120 degrees of flexion limited primarily secondary to the adiposity present in the posterior aspect of her thigh. She did have medial joint line tenderness that was exacerbated with hyperflexion of her knee. Her lateral jointline was relatively nontender. Her patellofemoral joint had no significant crepitus with motion. Ligamentous restraints to her patella were within normal limits. Provocative ligamentous stress testing which

included Lachman testing, posterior drawer testing, pivot shift testing and varus-valgus stressing was otherwise unremarkable.

Following his examination, Dr. Holland recommended surgery to repair respondent's torn meniscus.

15. Dr. Holland performed arthroscopic surgery on respondent's left knee on August 24, 2017. According to the operative report, in addition to the original tear to the medial meniscus observed in the May 16, 2017, MRI, Dr. Holland observed the following additional conditions in respondent's left knee: posterior horn lateral meniscus tear; chondromalacia on the medial facet of the patella, and synovitis. To rectify these conditions, Dr. Holland performed the following procedures: a partial posterior horn medial meniscectomy; partial posterior horn lateral meniscectomy; chondroplasty on the medial facet of the patella; and a partial synovectomy.

16. Dr. Holland saw respondent five days after the operation, on August 29, 2017. Upon examination, Dr. Holland found no drainage, redness, or clinical evidence of infection. Respondent's left knee motion ranged from full extension to 120 degrees of flexion. Respondent was ambulating with no visible limp and she had no swelling or tenderness. Respondent was referred to physical therapy.

17. Dr. Holland saw respondent on September 6, 2017, and removed her sutures. Dr. Holland recommended approximately six weeks of physical therapy, at which time, Dr. Holland expected respondent to return to at least modified duty.

18. Dr. Holland saw respondent on January 10, 2018. He noted that respondent is able to perform all activities of daily living without issue, although she still had subjective complaints of aches and pains in her left knee. Respondent told Dr.

Holland that she had tried steroid injections, physical therapy, acupuncture and medication, to control her pain, to no avail. However, when he examined respondent, he observed her scars had healed well; there was no swelling; there was no effusion; there was no redness or infection; her range of motion was from full extension to 130 degrees of flexion; respondent ambulated with no visible limp; and there was nothing remarkable regarding other testing he performed. He noted there was a mild amount of crepitus in the patella. He reassured respondent that her "aches and pains" were secondary to scar tissue and the patellofemoral chondromalacia and should improve with time. Respondent informed him that she had arranged with her insurance to seek a second opinion. Dr. Holland concluded respondent should return to modified duty to a sit-down position.

19. On January 30, 2018, respondent was evaluated by Keola Chun, M.D. Following an examination, Dr. Chun imposed a "prophylactic restriction precluding [respondent] from prolonged crouching, crawling, or squatting." Dr. Chun noted that respondent, at that time, had likely not achieved maximum medical improvement and that she should be evaluated further for "residual meniscal pathology."

20. Dr. Holland saw respondent on February 21, 2018. His opinion remained unchanged from his January 10, 2018, position.

21. Dr. Holland saw respondent on April 4, 2018. His opinion remained unchanged from his January 10, 2018, position, and he noted respondent had received her "second opinion" from Dr. Chun, and was going to undergo another MRI. Dr. Holland noted that perhaps the MRI might "shed light" on her symptomology (as nothing in his report showed any reason for respondent's complaints of pain).

22. Respondent underwent a second MRI on May 21, 2018. The MRI was interpreted by Sonja Moelleken, M.D. Other than some lateral patellar tilt and sublaxation with grade 2 patellar chondromalacia, nothing remarkable was observed. Dr. Holland again reassured respondent that the anterior-based pain was from her patellar chondromalacia and not anything having to do with the meniscus repair, thus, his treatment of her was completed. The amount of sublaxation was mild and there was no need for any further surgery. Dr. Holland recommended pain management if respondent continued to have pain.

23. Respondent saw Dr. Chun on August 18, 2018. Dr. Chun also reviewed the May 21, 2018, MRI report. Dr. Chun concluded that respondent would not be a candidate for additional arthroscopy because of the lack of surgical lesions. Dr. Chun also felt respondent had reached a point of maximum medical improvement. Dr. Chun recommended a "prophylactic restriction precluding [respondent] from prolonged crouching, crawling, or squatting.

24. Dr. Holland saw respondent on September 12, 2018. In the portion of the report regarding subjective complaints, Dr. Holland wrote:

> [Respondent] has been through multiple treatments since her surgery including several sessions of physical therapy, acupuncture, medication, bracing, and even steroid injection. She is [*sic*] continued to complain of anterior based knee pain and UI have performed an MIR arthrogram, which has not shown any significant abnormalities or new injuries to her knee other than patellofemoral chondromalacia. I have attempted to reassure [respondent] and get her back to full duty;

however, she has been **unwilling to return** to work because of the aches and pains in her knee. I have been requested that her care be transferred to Pain Management, who I feel is the appropriate doctor to help her. My request for transfer is pending utilization review. [Emphasis Added].

25. A progress note and work status report completed by Michael Marger, M.D., on March 29, 2019, did not show any new evaluations or examinations performed, or any objective evidence to support respondent's complaint of pain. Dr. Marger continued with the prophylactic restrictions that had previously been recommended by Dr. Chun, indicating that respondent was restricted from lifting pushing or pulling in excess of 10 pounds; only to engage in limited forceful pulling or pushing; limited stooping, bending, kneeling, and squatting.

26. A progress note and work status report completed by Neil Katz, M.D., on January 15, 2020, did not show any new evaluations or examinations performed, or any objective evidence to support respondent's complaint of pain. Dr. Katz continued with the prophylactic restrictions that had previously been recommended by Dr. Chun, indicating no running, jumping, kneeling, squatting, or climbing.

Undercover Video of Respondent

27. The following is a summary of the testimony of CalPERS Investigator Nelson Cooper: As part of the investigation concerning respondent's application for an industrial disability retirement, he conducted surveillance on respondent. Prior to doing so, he reviewed respondent's application. The videos were taken on multiple days. Investigator Nelson authenticated the videos and indicated that the parts on the video that were omitted were the parts where respondent was out of frame.

28. The videos were reviewed by the ALJ. The following is a summary of what is observed on the videos:

- June 18, 2020: Respondent is seen walking a small dog. Her gait is normal. She shows no signs of a limp of favoring one side over another. She steps on and off curbs with ease. She is obviously pregnant.

- June 25, 2020: Respondent is seen standing on a sidewalk talking to someone who is out of view. She stands in one place without any obvious difficulty for approximately six minutes, before walking around. As she walks around the street, as in the earlier video, there is nothing unusual about her gait. Later on in the video respondent is seen standing outside a building for approximately 10 minutes. Again, there was nothing unusual as she stood (i.e. she did not seem to be uncomfortable, did not shift her weight, did not do anything to indicate she was experiencing discomfort).

- July 8, 2020: Respondent is again seen in a video standing without issue talking to someone. She then walks with that person throughout the area, without issue. Her gait was normal. Her stride was normal. She stepped off a curb without issue. Respondent stood in line for some time without issue. Respondent goes into a store and exits with purchased items, still walking with a normal gait and carrying the items she purchased, along with a backpack. She easily gets into her car without showing any signs of pain or discomfort. Respondent is seen coming out of a Target store pushing a full shopping cart, again, with a steady gait and without issue. She changes direction forward, backwards, and twists to the side as she returns her shopping cart.

In sum, there is nothing in any of the video surveillance that would indicate respondent is in pain. At no time does she show any guarding of her knee; at no time does she show any favoritism to either side; at no time does she appear to change a gait or stride from anything but a normal pace; and at no time does respondent otherwise appear to change what activity she is doing due to pain or discomfort.

Expert Witnesses

TESTIMONY AND REPORT OF DR. YU

29. The following factual findings are based on the testimony of Dr. Yu, Dr. Yu's curriculum vitae, and a report completed by Dr. Yu.

Dr. Yu has been an orthopedic surgeon for 48 years and has served as an independent medical examiner for over 30 years. He recently retired in 2017. His specialties while he was practicing were orthopedic and sports medicine surgery. Dr. Yu obtained his B.S. in Biochemistry from the University of British Columbia in 1970. He obtained his M.S. in Chemistry from Kent State University in 1973. He obtained a Ph.D., with honors, in Biochemistry from the State University of New York, at Buffalo (SUNY), in 1973. He obtained his M.D. in an accelerated program at (SUNY), in 1981. He performed residencies in both general surgery and orthopedic surgery, in 1983 and 1986, respectively. Dr. Yu was the recipient of multiple fellowships in the field of orthopedics and is a member of the American Academy of Orthopaedic Surgeons, American Board of Orthopaedic Surgery, American Orthopaedic Society for Sports Medicine, Arthroscopy Association of North America, California Orthopaedic Association, and the Sigma XI Medical Honor Society. Dr. Yu has engaged in many professional enrichment activities in the area of sports medicine, including serving as a treating physician to competitive and professional figure skaters, skiers, gymnasts,

dancers, cyclists, runners, body builders, soccer players, football players, and baseball players. He has served on the faculty of the training camp for the United States Figure Skating Association, and also been a team physician for professional sporting teams. Dr. Yu has participated in 36 professional presentations in his field of specialty and is extensively published in peer-reviewed medical journals. Dr. Yu is an expert in the field of orthopedics and orthopedic surgery.

Dr. Yu was retained by CalPERS to examine respondent. Prior to examining respondent, he reviewed the job duties and physical requirements of a correctional officer and correctly noted them in his report. He reviewed respondent's medical reports dating back to April 17, 2017, when she was injured at work. The reports he reviewed were detailed in his report, many of which were also summarized above. The only report reviewed but not mentioned in Dr. Yu's IME report was the independent medical evaluation completed by Neil Ghodadra, M.D., respondent's expert retained for hearing. However, prior to the hearing, Dr. Yu did review Dr. Ghodadra's report and observed his testimony.

The meniscus is a smooth semicircular soft tissue shock absorber of the knee that is shaped like a crescent. It cushions the knee. If a person tears their meniscus, they may or may not have pain. Pain is what dictates whether surgery is appropriate. In respondent's case, the original MRI from May 17, 2017, showed a medial meniscus tear on the posterior horn, which was very minimal. There was some fraying near the chondral surface (kneecap), but that is not an injury; it is basically an arthritic condition that comes with the normal wear and tear of life. He also noted that neither the small cyst depicted in the MRI, nor the chondral fraying, would normally cause pain. The pain respondent felt would have come from the meniscus tear.

Dr. Yu explained that the purpose of the surgery respondent underwent was to trim back the damaged area of the meniscus and smooth it out in order to restore pain-free range of motion. Following respondent's surgery, reports showed respondent had no swelling or effusion and thus, in his opinion, the surgery completely resolved the injury suffered by respondent. There is no objective evidence in any of the reports to support respondent's subjective complaints of pain.

Dr. Yu conducted a comprehensive physical exam of respondent on November 17, 2020. His examination included an interview of respondent as well as a number of tests. Respondent reported to Dr. Yu that she experiences pain at a level of 6 to 8 out of 10 but before surgery her pain was only 5 to 6 out of 10. Respondent takes ibuprofen to manage the pain. Respondent claimed there is a popping sensation in her left knee and that her knee feels "weak and unstable." Respondent chooses not to wear a knee brace. She said she has difficulty standing, walking, and running for more than 20 minutes. Respondent also claimed right knee pain due to "overcompensating" with her left knee. Respondent claimed difficulty with her activities of daily living such as bathing, dressing, pulling up her pants, shaving her legs, climbing and descending stairs, doing housework, cooking, washing dishes, and grocery shopping. Respondent said she has to be extremely cautious when performing her activities and has to take breaks after performing them.

Respondent exhibited normal posture while sitting and standing. Alignment of her lower extremities was normal and symmetrical. She walked with a normal reciprocal progressive gain, and was able to squat. Respondent was able to do a "heel and toe walk" without difficulty. Nothing remarkable was noted about the cervical spine, dorsal spine, upper body, waist, lumbosacral spine, or hips.

Regarding respondent's knees, she had no signs of anything wrong with her right knee. Regarding her left knee, she had no effusion (fluid) or swelling. The McMurray's test, which is the standard test for meniscus pain, was negative. If a person has any pathology stemming from a problem with the meniscus, at some point during that test, there would be pain, but respondent had none. The Lachman and pivotal shift tests were negative, meaning there was no left knee joint instability and both the medial and lateral collateral ligaments showed no signs of tenderness, pain, or laxity. The left knee had "slight medial peripatellar discomfort." Respondent had normal flexion. Respondent had normal muscle strength in the lower extremities and no atrophy in either leg above or below the knees, which would be expected if respondent had the level of pain she claimed. Respondent had completely normal range of motion in all respects.

Regarding respondent's Grade 2 chondromalacia (observed on the May 17, 2017, pre-surgery MRI), this condition is a softening of the cartilage around the knee cap. The grades range from 0 to 4, with a grade of 4 being bone on bone. Chondromalacia is something that happens with age. It is a degenerative change that is mostly superficial, but can lead to early arthritis. The presence of chondromalacia does not mean a person will have pain. Usually there is no pain at all and that is why a doctor will do testing to determine the source of the pain. Nothing indicated respondent has pain from chondromalacia.

Dr. Yu viewed the videos of respondent taken by Investigator Nelson. He pointed out that in the videos respondent had a normal gait, strike pattern, cadence, and did not exhibit any overcompensation. Respondent did not show any problem standing on the sidewalk, uneven ground, and showed no favoritism of her left leg. Everything about respondent's walking rhythm and stride is normal. There was no

evidence on the video of the difficulties in respondent's activities of daily living, as she claimed.

Dr. Yu explained that he did not need to see any examples of respondent engaging in arduous activities (such as crawling, running, etc.) because if she had disabling pathology she would have corresponding physical evidence in her examination to support that pathology. The most critical finding in respondent's physical examination was that she had zero evidence of atrophy. Her surgery completely resolved the meniscus tear. Neither MRI taken pre or post-surgery showed evidence of swelling. Based on his examination and a review of the records, Dr. Yu would return respondent to full duty.

Dr. Yu was asked many questions on cross-examination, all designed to elicit an explanation regarding why other doctors (such as Dr. Holland, Dr. Chun, and Dr. Ghodadra) would place restrictions on respondent, yet Dr. Yu would not. Dr. Yu explained four major reasons for this. First, he pointed out that while Dr. Ghodadra found muscle weakness and swelling, there was no measurement of muscle strength and the atrophy measurement, showing 0.5 cm in the left quadricep, is within normal limits. Indeed, not one doctor in any of the countless reports he reviewed ever mentioned evidence of atrophy. Second, no doctors post-surgery ever found a positive McMurray test, which is a meniscus specific test. As such, there is no evidence of meniscus pathology. Third, no doctors found painful crepitation. Although some mentioned crepitus, none of them found it to be painful. Even in Dr. Ghodadra's report, there is physical evidence of patellar pain. Patellar tilt, though mentioned in records, is unremarkable because patellar tilt is not a pathological finding without other corresponding reasons for pain. Fourth, and most significant, no doctor found

joint effusion with the exception of Dr. Ghodadra, whose conclusion and restrictions do not correspond to any objective physical findings.

Based on the records and his examination, Dr. Yu concluded respondent is not substantially disabled from performing the usual and customary duties of a correctional officer for CDCR.

TESTIMONY AND REPORTS OF DR. GHODADRA

30. The following factual findings are based on the testimony of Dr. Ghodadra, Dr. Ghodadra's curriculum vitae, and a report completed by Dr. Ghodadra.

Dr. Ghodadra is an orthopedic surgeon. He obtained his B.S. in Biology and Doctor of Medicine degree from Duke University. At Rush University, he completed an internship in general surgery, a residency program in orthopedic surgery, and a fellowship in sports medicine. Dr. Ghodadra has been the Chief Medical Officer at Turn Pharmaceuticals since 2017. He has served in many other positions including medical advisor for Cure pharmaceuticals, Medical Advisor for Memorial Health, and an associate team physician for the Chicago Bulls (basketball) and Chicago White Sox (baseball). Dr. Ghodadra has received many awards and honors in his field and is extensively published in peer-reviewed journals and chapters in various books regarding orthopedic surgery. Finally, Dr. Ghodadra has made many professional presentations regarding orthopedics. Dr. Ghodadra is an expert in the field of orthopedics and orthopedic surgery.

Prior to examining respondent, Dr. Ghodadra reviewed the job duties and physical requirements of a correctional officer. He reviewed respondent's medical reports dating back to April 17, 2017, when she was injured at work. The reports he reviewed were detailed in his report, many of which were also summarized above.

Dr. Ghodadra conducted a physical exam of respondent's left knee on March 24, 2022. His examination included an interview of respondent as well as a number of tests. Respondent reported to Dr. Ghodadra that the pain level in her left knee is a 2 to 3 out of 10 at rest, but will increase to a 7 or 8. Respondent told him that if she stands or walks for 30 to 60 minutes she has "pain and at times swelling." She reported with prolonged bending of the knee, such as when sitting, squatting, or walking on uneven ground, she has increased pain. She avoids climbing stairs and does not run or jump. Respondent told Dr. Ghodadra she cannot perform heavy lifting.

Dr. Ghodadra found that respondent walked with a normal gait and she had no acute signs of distress. Examination (although it did not show what exam he performed), showed "trace effusion of the left knee" and 0.5 cm left quadricep atrophy. He found positive medial and lateral joint line tenderness, although he did not indicate what test he performed. McMurray's test (for the meniscus) was negative. The Lachman test was Grade 1A. The knee joint was found to be stable. The range of motion in the left knee was 0 to 125 degrees, and there was mild patella crepitation. There was no patella grind or patellar tilt. Respondent was able to walk heel to toe but complained of pain.

Dr. Ghodadra's impression of the video was:

> [Respondent] was seen standing and walking. She seemed to step slowly off of the curb, using her right foot first. She also carefully steps on the curb. It was noted that she was seen getting into a car, walking and going inside and outside of a Target and putting items in the car. The video showed that she is able to stand and walk. However, there

> was no significant arduous activities noted on the video provided.

In his evaluation of Dr. Yu's report, Dr. Ghodadra indicated "it appears he performed the evaluation via zoom" and he disagreed with Dr. Yu's conclusion. Dr. Ghodadra concluded respondent's job involves the ability to engage in prolonged walking, standing, working on uneven ground and restraining inmates. He further found:

> Given the serious nature of her job and the physical requirements, her left knee has incapacitated her from performing these activities. While she is able to perform some of the activities that involve standing and walking . . . her job does require the ability to apprehend and restrain inmates. This involves repeated bending, stooping, squatting, and extraordinary movement and strength to maintain control over the inmate without causing risk of harm to herself.....Based upon my review of her records and examination today, she has permanent incapacity given the findings at the time of arthroscopy and the noted patellar chondromalacia.....At this point, she has limitations due to this cartilage damage and has pain which is rated at 7-8/10 with symptoms of quad weakness. This will all prevent her from performing all of her work-related duties.

Regarding the video, Dr. Ghodadra added during his testimony that he believed respondent was stepping very slowly and carefully and that she was "leaning" toward

the right side, looking down, and stepping with her right foot first. He said that typically a person with pain will "shift" to the side that hurts less.

Dr. Ghodadra pointed to his objective measures, such as swelling in respondent's left knee and atrophy in her left quadricep, as evidence that support her subjective complaints of pain. He then testified that respondent "should" not engage in any repetitive kneeling or squatting, or perform any explosive activities or heavy lifting, as those activities might "aggravate" respondent's existing knee problem. Dr. Ghodadra explained that these restrictions are prophylactic because "we don't want it to get worse," but also said there is an "inherent inability" to do things that require certain force or heavy lifting. He stated the CalPERS disability standard as "the ability to go back to work and do what you need to do at that job."

During cross-examination, Dr. Ghodadra was asked whether there were any activities that respondent, to a degree of medical certainty, cannot do. He responded that respondent could do things that involve bending, stooping, squatting, etc., however, she should not lift or move more than 25 pounds because that might "cause more damage." He recommended the following restrictions: limiting the use of stairs to no more than 15 minutes, limiting running to no more than 15 minutes, no repetitive squatting, and limiting standing and walking to no more than four hours per day.

When asked whether Dr. Ghodadra's recommendation that respondent limit or not perform the above-referenced activities was based on a fear of causing additional injury, he answered, "correct" because the "fear" is that someone not be placed in danger.

EVALUATION OF EXPERT TESTIMONY

31. A person is qualified to testify as an expert if he has special knowledge, skill, experience, training, or education sufficient to qualify him as an expert on the subject to which his testimony relates. (*Chavez v. Glock, Inc.* (2012) 207 Cal.App.4th 1283, 1318-1319.) An expert witness may give opinion testimony based on matter (including his special knowledge, skill, experience, training, and education) perceived by or personally known to the witness or made known to him at or before the hearing, whether or not admissible, that is of a type that reasonably may be relied upon by an expert in forming an opinion upon the subject to which his testimony relates, unless an expert is precluded by law from using such matter as a basis for his opinion.

32. Relying on certain portions of an expert's opinion is entirely appropriate. A trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co*. (1973) 9 Cal. 3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id*. at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 767.) The fact finder may also reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

33. While both experts were deemed credible and exceptionally qualified in the field of orthopedics and orthopedic surgery, Dr. Yu's testimony and report were more persuasive than that of Dr. Ghodadra.

Dr. Yu's IME report was more thorough than that of Dr. Ghodadra. He conducted a comprehensive physical exam of respondent that included many tests specific to respondent's complaint of pain in her knee. He found no joint instability, no effusion, and no atrophy. Most important, Dr. Yu correctly stated the CalPERS "substantial incapacity" disability standard and based on that standard, his objective findings and review of previous reports showed nothing to substantiate respondent's subjective complaints of pain.

Dr. Ghodadra's examination indicated "trace" effusion and 0.5 cm quadricep atrophy. Based on his review of previous reports, which did not include any findings of effusion or atrophy, he nonetheless concluded that these constituted evidence to support respondent's complaint of pain. Yet, he noted the McMurray's sign, which is the "go-to" test for meniscus pathology, was negative. He pointed to respondent's diagnosis of Grade 2 chondromalacia also as evidence to support respondent's complaint of pain. However, as Dr. Yu explained, chondromalacia is rarely a cause of pain and respondent's meniscus tear has completely resolved according to the post-surgery MRI. More important, he disagreed with Dr. Ghodadra's conclusion that respondent's atrophy was evidence to support her complaint of pain because under 0.5 cm of atrophy is within normal limits and is not clinically significant.

Additionally, Dr. Ghodadra's observations regarding the video were contradicted by Dr. Yu. When viewed by the ALJ, the things observed by Dr. Ghodadra also were not seen by the ALJ. This is not at all suggesting that Dr. Ghodadra is not credible regarding his interpretation of the video, but, after review, Dr. Yu's interpretation is consistent with what the ALJ viewed on the video. As previously indicated, respondent was not observed to be having any problems going about her activities, and she was not observed to be favoring any particular side. She was not

observed to be proceeding with caution or otherwise being careful or walking slowly. It is noted that Dr. Ghodadra indicated respondent leaned to her right and stepped on and off the curb with her right leg, and that sometimes people who have pain favor their painful side. However, the medical reports also indicate that respondent is right-side dominant, and Dr. Ghodadra did not state (nor was he asked) if he took this fact into consideration and whether it would change his conclusion regarding the video, as it would not be uncommon for a right-side dominated person to always lead with their right leg.

Most important is that Dr. Yu correctly pointed out, and the medical reports supported, the fact that the restrictions recommended by all the doctors in the past several years were prophylactic in nature, as opposed to restrictions imposed because of a substantial incapability of doing those activities. Dr. Yu's conclusions were consistent with the CalPERS standard that no objective evidence showed respondent is substantially incapacitated from performing her duties as a correctional officer. Dr. Ghodadra's opinion, in his report and throughout testimony, suggested that his recommendations regarding restricted activities were prophylactic in nature because of a fear that respondent's perceived condition might become worse in the future. Dr. Ghodadra also explained his understanding of the CalPERS disability standard as "the ability to go back to work and do what you need to do at that job." That is not the CalPERS standard.

Accordingly, Dr. Yu's opinion was given more weight than that of Dr. Ghodadra in reaching a conclusion in this matter.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Absent a statutory presumption, an applicant for a disability retirement has the burden of proving by a preponderance of the evidence that he or she is entitled to it. (*Glover v. Board of Retirement* (1989) 214 Cal.App.3d 1327, 1332.)

Applicable Statutes

2. Government Code section 20026 defines "disability" and "incapacity for performance of duty" for purposes of a retirement, as:

> disability of permanent or extended duration, which is expected to last at least 12 consecutive months or will result in death . . . on the basis of competent medical opinion.

3. Government Code section 21150, subdivision (a), provides that a member who is "incapacitated for the performance of a duty" shall receive a disability retirement. Section 21151, subdivision (a), provides that such incapacitated member shall receive a disability retirement regardless of age or amount of service.

4. Government Code section 21152, provides in part: Application to the board for retirement of a member for disability 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. Government Code section 21153 provides:

Notwithstanding any other provision of law, 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 retirements as provided in section 20731.

6. Government Code section 21154 provides in part:

The application [for disability retirement] shall be made only (a) while the member is in state service, . . . On receipt of an application for disability retirement of a member, other than a local safety member with the exception of a school safety 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. On receipt of the application with respect to a local safety member other than a school safety member, the board shall request the governing body of the contracting agency employing the member to make the determination.

7. Government Code section 21156 provides that if the medical evaluation or other evidence demonstrates that an eligible member is incapacitated physically or mentally, then CalPERS shall immediately retire the member for disability. The determination of incapacitation must be based on competent medical opinion.

Appellate Authority

8. Disability is not an inability to perform fully every function of a given position. For nearly 40 years, the courts have consistently and uniformly held that Government Code section 20026, formerly Government Code section 21022, requires "substantial inability" to perform the applicant's "usual duties," as opposed to mere discomfort or difficulty performing those duties. (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 877.)[3] As such, when an employee can

[3] The applicant in *Mansperger* was a game warden with peace officer status. His duties included patrolling specified areas to prevent violations and to apprehend violators; issuing warnings and serving citations; and serving warrants and making arrests. He suffered injury to his right arm while arresting a suspect. There was evidence that Mansperger could shoot a gun, drive a car, swim, row a boat (but with some difficulty), pick up a bucket of clams, pilot a boat, and apprehend a prisoner (with some difficulty). He could not lift heavy weights or carry the prisoner away. The court noted that although the need for physical arrests did occur in Mansperger's job, they were not common occurrences for a fish and game warden. (*Id.* at p. 877.)

perform his or her usual and customary job duties, even though doing so may be difficult or even painful, the employee is not substantially incapacitated and does not qualify for an industrial disability retirement. (*Id*. at pp. 886-887.) Mere difficulty in performing certain tasks is also not enough to support a finding of disability. (*Hosford, supra,* 77 Cal.App.3d at p. 854.)

In determining the ultimate question of whether an employee is substantially incapacitated from performing his or her usual duties, the board must consider both a job description and a list of job demands placed on an employee as well as the duties actually performed by the employee. (*Hosford v. Bd. of Administration* (1977) 77 Cal.App.3d 854, 860-861[4]; *Beckley v. Board of Administration* (2013) 222 Cal.App.4th

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Similarly, the need for him to lift a heavy object alone was determined to be a remote occurrence. (*Ibid*.) In holding the applicant was not incapacitated for the performance of his duties, the court noted the activities he was unable to perform were not common occurrences and he could otherwise "substantially carry out the normal duties of a fish and game warden." (*Id*. at p. 876.)

[4] In *Hosford*, the court held that in determining whether an individual was substantially incapacitated from his usual duties, the courts must look to the duties actually performed by the individual, and not exclusively at job descriptions. Hosford, a California Highway Patrol Officer, suffered a back injury lifting an unconscious victim. In determining eligibility for a disability retirement, the court evaluated Hosford's injuries according to the job duties required of his position as a sergeant, as well as the degree to which any physical problem might impair the performance of his duties. Thus, the actual and usual duties of the applicant must be the criteria upon which any impairment is judged. Generalized job descriptions and physical standards are not

691, 699.) Moreover, the employee must be presently incapacitated; that disability might occur in the future due to aggravation of the condition or disability that is a prospective probability does not satisfy the requirements of the Government Code. (*Id*. at p. 863; *Wolfman v. Board of Trustees* (1983) 148 Cal.App.3d, 196.) The above-referenced appellate authority is also discussed thoroughly in several precedential decisions.[5] (*In the Matter of the Application for Reinstatement from Industrial Disability Retirement of Willie Starnes and Department of California Highway Patrol,* Case No. 2530, OAH No. L-1999060537, effective January 22, 2000; *In the Matter of the Application for Disability Retirement of Theresa V. Hasan and Department of Corrections [Parole and Community Services Division, Region II],* Case No*.* 2704, OAH No. N-1999100099, effective April 21, 2000; *In the Matter of the Application for Disability Retirement of Ruth A. Keck and Los Angeles County Schools [Glendora Unified School District]*, Case No. 3138, OAH No. L-19991200097, effective September 29, 2000.)

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controlling, nor are actual but infrequently performed duties to be considered. The *Hosford* court found that although Hosford suffered some physical impairment, he could still substantially perform his usual duties. The court also rejected Hosford's contention that he was substantially incapacitated from performing his usual and customary duties because his medical conditions created an increased risk of future injury.

[5] An agency may designate a decision as precedential authority that may be relied upon in future decisions if it contains a significant legal or policy determination of general application that is likely to recur.

Evaluation

9. After consideration of all evidence as a whole, which includes the evaluation of expert testimony contained in Factual Findings paragraphs 31 through 33 which are incorporated here by reference, a preponderance of the evidence did not establish that respondent is substantially incapacitated from performing the usual and customary functions of a correctional officer.

10. The video taken by Investigator Nelson depicted respondent performing many activities of daily living (grocery shopping, walking the dog, standing, visiting with other individuals). The video contradicts respondent's reports of pain to Dr. Yu, which she claimed was 6 to 8 out of 10, and in that respect, respondent's complaints of pain seemed greatly overexaggerated. Respondent told Dr. Yu she cannot perform simple activities of daily living. During the entirety of the videos provided, however, respondent's gait was steady, her stride was normal, she did not limp, she had no problem lifting either her lift or right knee to step up or down, she did not exhibit any guarding of her left knee as she changed planes (i.e. from a street to a curb), she had no problem standing for any length of time, and she did not appear at any time to be going about her activities in the "extremely cautious" manner, as she told Dr. Yu. In sum, while the video is not dispositive of whether respondent has a substantially disabling condition, it certainly did not depict a person who was experiencing such debilitating pain that she could not perform normal life activities. Dr. Yu similarly concluded that the video did not depict someone with a pain level as that claimed by respondent.

11. This is, essentially, a case about a subjective complaint of pain in search of an objective pathology. The objective physical evidence supported that respondent's surgery was successful. The meniscus tear was resolved. There were no

new tears noted. The follow-up MRI after the surgery did not indicate any new pathology that would cause the level of pain respondent claims. According to Dr. Yu, there was no muscle atrophy above the knee. There was no muscle atrophy below the knee. While Dr. Yu did not observe respondent crouching, sitting, running, or jumping (just a few of the movements respondent claims she cannot do for any length of time), if respondent is truly physically incapable of performing such activities, there should absolutely be corresponding objective physical evidence to support her claim. In other words, one would have expected respondent, based on her complaints, to have atrophy, additional tears, swelling, or some other physical sign to correspond to her pain. Yet, there was nothing noted in his exam, nor anything clinically significant noted in Dr. Ghodadra's exam.

12. Nor did the countless medical reports and progress notes[6] written by Dr. Holland, Dr. Chun, or Dr. Katz contain objective physical evidence to support respondent's complaints of substantially disabling pain, and the reports written by each did not contain clinically significant evidence to support their conclusions that respondent needed the imposed prophylactic restrictions. As Dr. Yu explained, because there was no objective evidence or testing that would correspond to respondent's subjective complaints of pain, the modified duty restrictions (which were typically no running, crouching, crawling, or squatting and even described as prophylactic by Dr. Chun), were not warranted. Prophylactic restrictions are not the

[6] It is noted that all of the medical reports and progress notes detailed in Factual Findings paragraphs 12 through 26 constitute administrative hearsay under Government Code section 11513, subdivision (d), and cannot be used to support a finding of fact. They can, however, be used to supplement or explain other evidence.

same as saying someone is physically incapable of performing those movements. For purposes of CalPERS disability, a person must be physically incapable, to a substantial degree, of performing their job duties. Mere pain or discomfort in performing one's duties, under statutory law, appellate law, and precedential decisional authority, is not a basis for disability retirement. The prophylactic restrictions contained in the medical reports and progress reports do not indicate that respondent is unable to physically perform her job.

13. Respondent's testimony regarding the occasional pain she experiences in her knee was credible. However, insufficient competent medical evidence was offered to establish that the pain respondent feels in her left knee renders her substantially disabled from performing the usual duties of a correctional officer with CDCR. The evidence also did not establish with medical certainty that if respondent were to return to work and engage in the usual and customary duties of a correctional officer that doing so would cause her to become disabled. Accordingly, respondent did not meet her burden and her appeal is denied.

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ORDER

The application for industrial disability retirement filed By Atziri Villagomez with the California Public Employees' Retirement System on June 1, 2017, is denied. California Public Employees' Retirement System's denial of Atziri Villagomez application, due to orthopedic (left knee) conditions, is affirmed.

DATE: May 27, 2022

Kimberly J. Belvedere

KIMBERLY J. BELVEDERE

Administrative Law Judge

Office of Administrative Hearings