ATTACHMENT A

THE PROPOSED DECISION

Attachment A

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

In the Matter of the Application for Disability Retirement of:

THERESE A. HORTON, Respondent,

and

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES,

CALIFORNIA DEPARTMENT OF CORRECTIONS AND

REHABILITATION, Respondent,

Agency Case No. 2022-0352

OAH No. 2022060891

PROPOSED DECISION

This matter was heard before Administrative Law Judge Ed Washington, Office of Administrative Hearings, State of California, via videoconference from Sacramento, California, on March 20, 2023.

Staff Attorney Nhung Dao represented the California Public Employees' Retirement System (CalPERS).

Attorney Ellen Mendelson represented Therese A. Horton (respondent).

CalPERS properly served California Correctional Health Care Services, California Department of Corrections (CDCR) with the Statement of Issues and Notice of Hearing. CDCR made no appearance. This matter proceeded as a default against CDCR pursuant to Government Code section 11520, subdivision (a).

Evidence was received and the hearing concluded. The record remained open to allow the parties to submit written post-hearing briefs. The record closed and the matter was submitted for decision on April 12, 2023.

ISSUE

Was respondent substantially incapacitated from performing her usual and customary duties as a Staff Services Manager I (SSM I) for CDCR due to a rheumatological condition (chronic fatigue syndrome or myalgic encephalomyelitis or postural orthostatic tachycardia syndrome) when she filed her disability retirement application?

FACTUAL FINDINGS

Background

1. Respondent worked as an SSM I for CDCR when she filed a Service Pending Disability Retirement Election Application. By virtue of her employment with CDCR, respondent is a state industrial member of CalPERS subject to Government Code section 21151.

Respondent's Application for Disability Retirement

2. On August 16, 2021, respondent signed and thereafter filed with CalPERS a Service Pending Disability Retirement Election Application (application). On the application, respondent described her disability as: "Chronic Fatigue Syndrome," which is also known as Myalgic Encephalomyelitis (ME/CFS).[1] She specified that her disability occurred on December 10, 2019, and that it occurred due to "chronic condition." Respondent described her limitations and preclusions due to this condition as: "cognition, fatigue, unpredictable attendance, pain." Respondent specified that ME/CFS affects her ability to perform her job as follows: "Inability to focus, inability to retain information, not enough energy to complete tasks." Respondent supplemented her application to also identify Post Orthostatic Tachycardia Syndrome (POTS),[2] as a basis for her claimed incapacity. She specified that POTS prevents her from performing

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[1] The Mayo Clinic online dictionary defines "Myalgic Encephalomyelitis/Chronic Fatigue Syndrome" as a complicated disorder of unknown cause that causes extreme fatigue that lasts for at least six months and has symptoms that worsen with physical or mental activity but don't fully improve with rest. (https://www.mayoclinic.org/diseases-conditions/chronic-fatigue-syndrome/symptoms-causes/syc-20360490)

[2] The WebMD online dictionary defines "Postural Orthostatic Tachycardia Syndrome" as a disorder in which most of your blood stays in your lower body when you stand up, and in response, your heart rate jumps. … It can make you feel dizzy, lightheaded, or faint. (https://www.webmd.com/heart-disease/atrial-fibrillation/postural-orthostatic-tachycardia)

her specific job duties as follows: "Unable to stand over 10 mins, unable to sit for over 10 mins without getting lightheaded and confused."

3. CalPERS obtained medical records and reports on respondent's condition. This included a report prepared by Scott T. Anderson, M.D., who performed an Independent Medical Evaluation (IME) of respondent concerning her condition and application for disability retirement. After reviewing the information, CalPERS determined respondent was not substantially incapacitated from the performance of her duties as an SSM I for CDCR.

4. By letter dated February 4, 2022, CalPERS notified respondent that her application for disability retirement had been denied. Respondent timely appealed the denial. On September 19, 2022, respondent amended her application to include POTS as a new condition. On January 20, 2023, CalPERS received additional information regarding respondent's claimed POTS. This information was reviewed by Dr. Anderson but did not change any of the conclusions he reached after completing his IME.

Duties of a CDCR SSM I

5. The CDCR duty statement for the SSM I specifies that approximately 40 percent of the time, an SSM I assigned to Telemedicine Services performs the following essential job functions:

> Trains, supervises, and evaluates a multi-disciplinary unit of analytical and clerical administrative staff. Ensures that administrative staff work is completed on behalf of the Telemedicine Services program. Monitors unit activities and ensures compliance with multi-phase project plan deadlines. Tracks unit assignments, and prioritizes

assignments in accordance with the program's current strategic emphasis and timeliness. Ensures the unit provides adequate administrative support to multi-faceted project plan.

6. Approximately 30 percent of the time, an incumbent:

> Supports the staff in completing projects for Telemedicine Services, including analysis of data for reports, validation of data, and development of policies and procedures. Independently performs the highest-level staff work, such as assessing the progress in meeting Work Plan objectives. Identifies barriers in Work Plan implementation and independently resolve barriers. Directs and coordinates the activities of special project teams in the completion of complex staff work that overlaps into multiple disciplines and involves staff of various classifications … Reviews and edits completed staff work created by staff within the unit to ensure thorough analysis, appropriate recommendations, clear communication of ideas and arguments, and credible use of data.

7. An incumbent must also participate in meetings, prepare status reports, initiate and manage new projects, coordinate planning, manage and oversee Telemedicine Services budget and inventory. They must also identify and address resource needs and perform other related duties.

8. Respondent submitted a Physical Requirements of Position/Occupational Title form with her application, completed by a CDCR human resources representative, which details the type, duration, and frequency of physical tasks an SSM I must perform. The document specifies that an SSM I for CDCR must constantly (more than five hours a day) supervise staff, sit, and use a computer. An incumbent must frequently (from two-and-a-half to five hours a day) interact with coworkers in person or by phone. An SSM I must also infrequently (five to 30 minutes a day) lift and carry up to 10 pounds, stand, walk, bend at the neck and waist, twist at the neck and waist, and reach both above and below shoulder level.

Respondent's Evidence

RESPONDENT'S TESTIMONY

9. Respondent is 52 years old. Before working as an SSM I, respondent worked as a Staff Services Analyst, and as an Associate Governmental Program Analyst (AGPA). While working for CDCR, she was assigned to California Correctional Health Care Services Elk Grove campus. She supervised four to five AGPA's, served a significant patient base, and coordinated performing her job functions while complying with Health Insurance Portability and Accountability Act (HIPAA) regulations.

10. Respondent testified that she has ME/CFS and POTS, and that any standing, walking, and sitting at a desk makes her feel lightheaded, weak, faint, exhausted and experience "brain fog." She stated this stems wholly or in part from issues with blood flow to her brain and that the symptoms are lessened when she lies down.

11. Respondent's condition started in or around 2014. She saw her doctor and complained of fatigue. Her doctor recommended increased exercise, which was ineffective. Respondent's symptoms worsened with time and became unpredictable. She found it increasingly difficult to work. Respondent believes working fewer hours would have been helpful. However, she is a supervisor and is not allowed to work part-time. Respondent experienced increased difficulty processing information and could no longer effectively supervise. She also began to experience urinary urgency. When she must stand, she has "about 15 minutes of usable energy" before she is no longer effective and must lie down. She even occasionally falls asleep while standing.

12. Respondent was ultimately evaluated and diagnosed with ME/CFS and POTS. Her treatment program requires that she manage her energy and prevent her heart rate from exceeding 92 beats per minute. She periodically uses a wheelchair to conserve energy. If walking is required, she limits the distance she walks to no more than 100 feet.

RESPONDENT'S CPET TEST REPORT

13. Respondent submitted a Cardiopulmonary Exercise Test (CPET) Evaluation Report, completed by Christopher Snell, Ph.D., of the Workwell Foundation on August 8, 2022. This document was admitted into evidence as administrative hearsay and has been considered to the extent permitted under Government Code section 11513, subdivision (d).[3]

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[3] Government Code section 11513, subdivision (d), in relevant part provides:

> Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely

14. The purpose of the CPET evaluation was to examine respondent's metabolic, cardiovascular and pulmonary function after experiencing physical stress. According to the report, respondent had abnormal results in response to metabolic response testing, workload testing, cardiovascular response testing, respiratory response testing, and recovery response testing. Respondent's respiratory response test showed some values of exhaled carbon dioxide were marginally reduced, which could indicate impaired ventilatory efficiency. Respondent's peak respiratory rate was also below normal. As for respondent's recovery response, the report states that following testing respondent experienced the following:

> Profound fatigue despite significant rest, breathing problems, widespread aches, flushing, chills, itching, night sweats, disturbed sleep, dizziness/lightheadedness, fainting, sensitivity to sun/light and cognitive difficulties. [Respondent] was not recovered 7 days post-testing.

15. The CPET report findings specify that respondent's testing demonstrates "cardiopulmonary anomalies, low function and delayed recovery with severe symptom exacerbation post-exertion" which will severely limit respondent's ability to engage in normal daily activities and preclude employment of even a sedentary nature.

TESTIMONY OF ERICA SKY

16. Erika Sky has known respondent for approximately six years. During that time, they worked together in CDCR's Telemedicine Services unit. Ms. Sky was

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> objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions.

respondent's supervisor for two years, until respondent promoted to a managerial position in 2018. Respondent led an active lifestyle when they first met, participated in half-marathons, and engaged in many activities with her children.

17. Ms. Sky is familiar with respondent's work responsibilities with CDCR. She noted that respondent's duties as a first-line supervisor were critical to CDCR's telemedicine care. The position is very customer service oriented and requires significant mental effort. She recalled that respondent successfully completed several special projects for CDCR and was good at working with data.

18. Respondent initially performed her job very well. Subsequently, respondent experienced health issues and seemed to struggle with her duties. Ms. Sky spoke with respondent about these changes and respondent complained of fatigue. Some of respondent's duties were reassigned to address this issue. Respondent also took medical leaves of absence and worked on an intermittent schedule, based on her doctor's recommendations.

19. When respondent returned to work on a regular basis, it was apparent to Ms. Sky that driving to work regularly was too fatiguing for respondent. Respondent was temporarily approved to work from home, but the job was still very demanding when working remotely. Despite several attempts to accommodate respondent, her symptoms only worsened. Respondent took more time off, applied for catastrophic leave, and ultimately stopped working completely.

Expert Testimony

SCOTT ANDERSON, M.D.

20. CalPERS called Scott Thomas Anderson, M.D., as its expert at hearing. Dr. Anderson is a clinical professor in the Division of Rheumatology, Allergy, and Clinical Immunology, Department of Medicine, at the University of California at Davis, School of Medicine. He obtained his medical degree from the University of Texas Southwestern Medical School, Dallas, in 1986. He also obtained a Ph.D. in Medical Anthropology from the University of California at San Francisco-Berkeley, in 1998. Dr. Anderson is also a board-certified diplomate in internal medicine. He works as a medical consultant and performs IMEs and qualified medical evaluations for a variety of entities.

21. On December 14, 2021, Dr. Anderson performed an IME on respondent to determine whether she was substantially incapacitated from performing her job duties based on her reports of ME/CFS. Dr. Anderson's evaluation included interviewing respondent and reviewing her medical history, occupational history, social history, and current symptoms. The evaluation also included a physical examination of respondent, a review of respondent's medical records, and a review of respondent's job functions. Dr. Anderson detailed his evaluation, along with his findings and conclusions, in a 12-page IME report.

22. During the interview, respondent's chief complaint to Dr. Anderson was that her condition "is cumulative" and began to develop in 2014. She continued to work until her condition prevented her from doing so in 2021. Respondent reported a history of alcoholism but stopped drinking in 2011. Before 2011 she drank alcohol excessively, which resulted in deconditioning, weight gain, and fatigue.

23. Respondent’s reported symptoms during the evaluation included uncontrollable movement, tremors, muscle tics and twitches, and oral and nasal ulcerations. She reported an overall lack of energy and somnolence after working, shopping or socializing. Respondent has no history of encephalitis, meningitis, polymyositis, muscular dystrophy or other specific diagnosis relative to neuromuscular function. Respondent drove herself to her appointment with Dr. Anderson and stated that she can bathe, toilet and dress herself. She walked, sat, followed instructions, and communicated with Dr. Anderson during the evaluation without issue. When discussing the performance of her specific job duties, respondent told Dr. Anderson “I can do it all,” but emphasized that performing those duties results in extreme and debilitating fatigue.

24. During the evaluation, respondent was measured at five feet, six inches tall, and weighed 220 pounds. Dr. Anderson found no significant abnormalities during his physical examination of respondent. There was no muscle wasting, her right and left extremities had consistent circumference, and her hands had good digital alignment and strength. Respondent appeared depressed and anxious. However, her neurological exam was normal.

25. Respondent’s medical records indicated she had frequent interactions with multiple treating physicians for various reasons. Two physician’s records specifically refer to ME/CFS, and respondent is also described as having adjustment disorder with mixed anxiety, depression, and myofascial pain.

26. Dr. Anderson made no specific diagnosis at the conclusion of his evaluation but noted that no specific rheumatological condition was found and that he would not diagnose respondent with ME/CFS. Dr. Anderson opined that ME/CFS is a diagnosis of exclusion. He also noted there were several alternative bases for her

reported fatigue. This included severe obesity, a history of alcoholism, sleep apnea, depression and anxiety, prior anemia, and generalized deconditioning. He noted that some of these conditions are treatable through lifestyle changes.

27. Dr. Anderson determined that respondent did not have an actual or present rheumatological impairment such as ME/CFS that rises to the level of substantial incapacity. Instead, he opined that respondent has generalized mild fatigue due to deconditioning, obesity, and potentially treatable non-rheumatological medical or psychiatric conditions. He also concluded that respondent could perform all substantial and relevant job duties, including walking, sitting, answering emails, typing memos, communicating with others, engaging in precision and power grasping and perform necessary cognitive functions.

28. Dr. Anderson also determined that respondent's reported symptoms were out of proportion to his physical findings, as she had no muscle wasting, weakness, objective muscular weakness, joint deformity, muscle deformity, or other pathology that would support that she is substantially incapacitated based on a rheumatological disease of any type. Dr. Anderson acknowledged that ME/CFS is referenced as a specific diagnosis in respondent's medical records but stated this may be due to the tendency for information presented to one provider being brought forward from another without supportive objective findings.

29. At CalPERS's request, Dr. Anderson prepared three supplemental IME reports, dated March 18, 2022, September 6, 2022, and January 24, 2023, after receiving additional medical records and information about respondent's conditions and symptoms for consideration. This supplemental information included the addition of POTS as a basis for disability retirement. After reviewing the additional records, Dr. Anderson reiterated that respondent had no condition that would justify medical

retirement under the CalPERS system, as the additional information did not alter his opinion that respondent was not substantially incapacitated from the performance of her duties as an SSM I for CDCR.

TODD DAVENPORT, DPT

30. Respondent called Todd Davenport, DPT, as her expert at hearing. Dr. Davenport is a licensed physical therapist in California. He is not an M.D., or Doctor of Medicine, but holds a Doctor of Physical Therapy degree, which he obtained from the University of Southern California in 2002. He also received a master's degree in public health from the University of California at Berkeley in 2016. He has been a board-certified clinical specialist in orthopedic physical therapy for 18 years.

31. Dr. Davenport testified that he is familiar with ME/CFS and how one of its identifying symptoms is experiencing post-exertional malaise or "crashes." He is aware that respondent has been diagnosed with ME/CFS and POTS and has treated her condition in conjunction with her other doctors. Dr. Davenport testified that these are "very disabling" conditions that can be more disabling than multiple sclerosis, stroke, or cancer. In respondent's case, she is exhausted after minimal exertion and is prevented from doing work when positioned with her head over her feet.

32. Dr. Davenport reviewed respondent's CPET test results and determined that they supported her ME/CFS diagnosis and her claimed inability to perform her job duties. He noted that the test results identifying respondent's respiratory deficiencies and extended recovery period cannot be faked. Dr. Davenport also asserted that ME/CFS is not a rheumatological disease and opined that an assessment of respondent's condition and abilities should be completed by a neurologist or infectious disease specialist, rather than a rheumatologist, as the latter is not required

to possess or maintain competency in ME/CFS. He reviewed Dr. Anderson's IME reports and disagreed with Dr. Anderson's conclusions as to respondent's limitations and ability to work. He noted that Dr. Anderson failed to identify any additional information obtained during the IME that would add to, alter, or rebut respondent's previous ME/CFS diagnosis. He believed respondent's uniform limb size and muscle strength were non-factors, as they would not be affected by ME/CFS. Dr. Davenport also noted that Dr. Anderson recommended treatment through exercise. He stated this recommendation was "outdated" and may actually be harmful to a patient with ME/CFS.

ADDITIONAL DOCUMENTARY EVIDENCE

33. Respondent submitted a written rebuttal to Dr. Anderson's September 6, 2022, IME report, prepared by Dr. Snell. In this rebuttal, Dr. Snell disputed many of Dr. Anderson's findings and conclusions. He specifically noted that it is unremarkable that respondent has no asymmetry in size or muscle wasting of extremities and has good hand strength. Dr. Snell also noted that ME/CFS is not a rheumatological condition, but instead is considered a systematic disorder consisting of many complex symptoms that may vary in frequency, duration and severity. Dr. Snell asserted there is a general lack of knowledge regarding ME/CFS in the medical community and implied that was apparent in Dr. Anderson's IME reports. He emphasized that multiple indicators from respondent's testing support that she in fact has ME/CFS and that those indicators are not the result of a sedentary lifestyle. He also noted that exercise has been known to exacerbate ME/CFS. Dr. Snell opined in his rebuttal that, despite Dr. Anderson's conclusions, full-time employment poses an unavoidable risk to respondent.

34. Respondent also submitted a letter from Jamila Hyder Champsi, M.D., which included CalPERS's Supplemental Physician's Report on Disability describing

respondent’s POTS. Dr. Champsi stated in her letter that respondent meets the criteria for ME/CFS, and that she is treating respondent for that condition and for POTS. She described ME/CFS as “a serious disabling medical condition that is believed to stem from a defect in mitochondrial energy metabolism.” She described the common symptomology of the condition and noted that respondent has experienced persistent fatigue, disrupted sleep, and grogginess for extended periods. Dr. Champsi concluded her letter by specifying that respondent wants to work but is severely limited by her fatigue, decreased ability to stand, and decreased cognitive function.

Analysis

35. Respondent sought disability retirement based on claimed ME/CFS and POTS. There was a relatively small amount of information produced at hearing regarding POTS, and the evidence that was presented regarding this syndrome seemed ancillary or supplemental to the assertion that she has ME/CFS to such a degree that she is incapacitated from performing her regular job duties. This analysis aligns with respondent’s focus on ME/CFS as the primary, but not sole, basis for her application.

36. This is a challenging case from an evidentiary standpoint, as ME/CFS is a medical condition that is still controversial as a category and is not fully accepted within the medical community. ME/CFS in essence is long standing fatigue without a discernable cause. The syndrome is a collection of pains or symptoms catalogued together for convenience of discussion. It is considered a diagnosis of exclusion and is often used when symptoms are unexplainable in etiology after all evaluations have failed to establish specific causes supported by competent medical evidence.

37. Dr. Anderson’s opinion that respondent was not substantially incapacitated from performing her usual job duties was persuasive. His IME reports were detailed and thorough, and his testimony at hearing was clear and comprehensive. The results of his physical examination, assessment of respondent’s medical records, and medical history supported his opinion. Respondent drove to the evaluation and walked, sat, and communicated without issue. There were no abnormalities observed during her physical examination to support that she had ME/CFS or POTS, nor any other rheumatological condition. Dr. Anderson determined, based on respondent’s condition and medical history, that her symptoms could easily be attributed to her deconditioning or history with alcoholism, rather than ME/CFS or POTS. Moreover, respondent told Dr. Anderson that she could perform “all” of her job duties, but would become exhausted to a debilitating degree after performing those duties. He found no competent medical evidence during his evaluation and review of supplemental documents to support that respondent was unable to perform any of her job duties.

38. Conversely, respondent testified to a collection of symptoms without supportive competent medical evidence as to the cause or even an effective treatment of her claimed conditions. She submitted a CPET report prepared by Dr. Snell, which specified that respondent has cardiopulmonary abnormalities and delayed recovery with severe symptoms post-exertion and that these symptoms preclude her from employment. However, the report included no analysis relative to respondent’s specific job functions nor reflected that the author had reviewed respondent’s job description. Respondent also submitted medical reports from Dr. Champsi, which contained the same deficiencies. She did not call Drs. Snell nor Champsi to testify at hearing.

39. Respondent also asserted that ME/CFS is not a rheumatological condition and that Dr. Anderson, a rheumatologist, lacks the knowledge and experience to properly assess the condition and its effects. She presented testimony through Dr. Davenport that an evaluation by a neurologist or infectious disease specialist may be more useful in determining respondent's level of incapacity. However, respondent called no neurologist or infectious disease specialist to testify at hearing and failed to present any reliable evidence from an expert arguably more qualified than Dr. Anderson to provide expert opinion.

40. Respondent called Dr. Davenport, her physical therapist, to testify at hearing. He testified to his understanding of ME/CFS and its effects. However, his observations and conclusions were largely outside of the scope of practice of a physical therapist. He also testified as to the significance and meaning of the information contained in the reports prepared by Drs. Snell and Champsi. However, the information contained in those reports are hearsay and do not constitute competent medical opinion, as the authors did not testify at hearing. Hearsay evidence is not sufficient in itself to support a factual finding in this matter (Gov. Code, § 11513, subd. (d)).

41. The burden was on respondent to offer evidence at hearing to support her disability retirement application. However, when all the evidence is considered, respondent failed to offer sufficient competent medical evidence to establish that, when she applied for disability retirement, she was substantially and permanently incapacitated from performing the usual duties of an SSM I for CDCR. Accordingly, her application for disability retirement must be denied.

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 had to prove that, when she applied, she was "incapacitated physically or mentally for the performance of [her] duties in the state service." (Gov. Code, § 21156.) The party asserting the affirmative at an administrative hearing has the burden of proof, including the initial burden of going forward and the burden of persuasion by a preponderance of the evidence. (*McCoy v. Bd. of Retirement* (1986) 183 Cal.App.3d 1044, 1051.)

3. "Disability" and "incapacity for performance of duty" as a basis of retirement, mean disability of permanent or extended, which is expected to last at least 12 consecutive months or will result in death, as determined by the board … on the basis of competent medical opinion. (Gov. Code, § 20026.)

4. 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." (Italics in original.) The court in *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 855, 863, 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. 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.)

5. When all the evidence is considered in light of the analyses in *Mansperger, Hosford*, *Smith*, and *Keck*, respondent failed to submit sufficient evidence based upon competent medical opinion that, when she applied for disability retirement, she was permanently and substantially incapacitated from performing the usual duties of an SSM I for CDCR. Consequently, her disability retirement application must be denied.

ORDER

The application of respondent Therese A. Horton for disability retirement is DENIED.

DATE: May 22, 2023

Ed Washington

ED WASHINGTON

Administrative Law Judge

Office of Administrative Hearings