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: SANDRA L. WOODY, Respondent, and DEPARTMENT OF DEVELOPMENTAL SERVICES, PORTERVILLE DEVELOPMENTAL CENTER, Respondent.	Case No. 2010-0553 OAH No. 2013040594

PROPOSED DECISION

This matter was heard before Administrative Law Judge Marcie Larson, State of California, Office of Administrative Hearings, on December 5, 2013, in Fresno, California.

The California Public Employees' Retirement System (CalPERS) was represented by Preet Kaur, Staff Attorney.

Sandra L. Woody (respondent) was present and represented herself.

There was no appearance by or on behalf of the Department of Development Services (Department). The Department was duly served with Notices of Hearing. The matter proceeded as a default against the Department, pursuant to California Government Code section 11520, subdivision (a).

Evidence was received, the record was closed, and the matter was submitted for decision on December 5, 2013.

ISSUE

The issue on appeal is whether, on the basis of orthopedic conditions which include the left side of respondent's neck, left shoulder, arm, elbow and hand, respondent is permanently disabled or incapacitated from performance of her duties as a Psychiatric Technician (PT) for the Department.

PROCEDURAL FINDINGS

1. On August 17, 2009, respondent signed and thereafter filed an application for industrial disability retirement (application) with CalPERS. Until July 28, 2009, respondent was employed as a PT by the Department.[1] 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 orthopedic conditions, which include the left side of her neck, left shoulder, arm, elbow and hand (orthopedic conditions).

3. CalPERS obtained medical records and reports prepared by William Previte, D.O., Charles Lewis III, M.D., Andrew Whyman, M.D. and Ernest Miller, M.D., concerning respondent's orthopedic conditions. After reviewing the reports, CalPERS determined that respondent was not permanently disabled or incapacitated from performance of her duties as a PT for the Department.

4. On June 21, 2010, CalPERS notified respondent that her application for industrial disability retirement was denied. Respondent was advised of her appeal rights. Respondent filed an appeal and request for hearing by letter dated July 9, 2010.

5. On July 31, 2012, Anthony Suine, in his official capacity as Chief, Benefit Services Division, Board of Administration, CalPERS, made and thereafter filed the Statement of Issues.

FACTUAL FINDINGS

Respondent's Employment History

1. Respondent worked for the Department at the Porterville Developmental Center (Porterville) as a licensed PT until her last date of service on July 28, 2009, when she was 58 years old. Respondent had worked at Porterville since 1997, in various capacities.

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[1] The Statement of Issues provides that on July 29, 2009, respondent signed an application for service retirement and service retired effective that date. However, the date of respondent's service retirement was not established by the evidence at hearing.

Duties of a Psychiatric Technician

2. Porterville is a residential facility for children and adults with mental and/or developmental disabilities. The facility provides care and medical services for forensic and non-forensic residents.

3. As set forth in the duty statement signed by respondent on March 18, 2006, as a PT for the Department, respondent was required to provided "a safe, clean, and home-like environment for residents for an assigned group of forensic clients, or non-forensic clients residing in a home with forensic clients..." A PT serves as a primary care provider for all residents in assigned group areas. The typical physical demands of the position include, in part, escorting clients to different areas on or off campus for appointments and scheduled trips. As a PT, respondent was also required to stand for long periods of time and respond to all behavioral and/or medical interventions as required. Respondent was also required to possess and maintain sufficient strength, agility, endurance, and sensory ability to perform the duties contained in the duty statement.

4. On August 17, 2009, CalPERS received a completed "Physical Requirements of Position/Occupational Title" (Physical Requirements), signed by a representative of respondent's employer and respondent. According to the Physical Requirements, when working as a PT, respondent: (1) constantly (over six hours a day) stood, engaged in simple grasping and repetitive use of her hands; (2) frequently (three to six hours a day) walked, bent and twisted at her neck and waist, reached above and below the shoulder, pushed and pulled, engaged in fine manipulation and lifted and carried up to 50 pounds; (3) occasionally (up to three hours) sat, ran, crawled, kneeled, climbed, squatted, power grasped, used a keyboard and mouse, lifted from 51 to 75 pounds, walked on uneven ground, drove, was exposed to excessive noise, extreme temperatures, humidity, wetness, dust, gas, fumes or chemicals, and bio-hazards; (4) never lifted over 76 pounds, worked with heavy equipment, worked at heights, operated foot controls or repetitive movement, or used special visual or auditory protective equipment. Under the "comments or additional requirements" section of the form, it states "required to participate in Active Treatment Crisis Management (client containment)."

5. Lori Duckworth, a Program Director at Porterville, testified at the hearing in this matter. For the last eight years, Ms. Duckworth has overseen four programs at Porterville that provide housing for forensic clients who require secure treatment. Secure treatment requires 24 hour supervision of clients by staff for six units that house up to 16 clients. Ms. Duckworth testified that respondent worked in "Program 9" which consisted of forensic clients that require secure treatment.

6. As the Program Director and former PT, Ms. Duckworth is familiar with the physical demands of respondent's position which can vary depending on which program a PT is assigned. Ms. Duckworth explained that the position requires sitting for up to three hours, frequent standing and walking, frequent pushing, pulling and grasping. Lifting and

carrying requirements vary depending on the program assignment. In Program 9, lifting and carrying would be rare. Overhead reaching was also required, but the frequency would depend on the duties assigned for the day. Client containment, which requires a PT to restrain a client if necessary, can occur up to one time per month, depending on the program to which a PT is assigned.

Respondent's Work Injury

7. On or about November 29, 2005, respondent was injured when she assisted in a containment of a client. At hearing, respondent testified that while on duty at Porterville, she was walking to the restroom and saw a client attacking an employee. Respondent attempted to assist the employee. The client grabbed respondent, pulled her hair and "threw her around." Respondent and the client fell to the floor. The client landed on top of respondent. At the time, respondent's left arm was behind her back. Respondent fractured a rib during the assault.

Physician's Report on Disability

8. On August 4, 2009, respondent's primary treating physician Charles Lewis III, M.D. signed a "Physician's Report on Disability" form which was filed with CalPERS in support of respondent's application. On the form, Dr. Lewis listed in Section 4, respondent's first diagnosis as "cervical, thoracic, lumbar-sprain/strain, myofascial syndrome."[2] Under the section "restriction/limitations," Dr. Lewis wrote "no forceful use of left upper ext. below."

The second diagnosis Dr. Lewis listed was "left shoulder pain, strain/sprain, impingement syndrome." Under the "restriction/limitations" section on the form, Dr. Lewis wrote "no above shoulder level, no receptive overhead work."

In the Section 4 "comments" section on the form, Dr. Lewis wrote "Patient is also precluded from working in environment in which there could potentially occur altercations or violence."

9. Dr. Lewis marked the "yes" box in response to Section 5, question 1 on the form: "Is the member currently, substantially incapacitated from performance of the usual duties of the position for their current employer?"

10. Dr. Lewis marked the "no" box in response to Section 5, question 3 on the form: "Was the job description/duty statement reviewed to make your medical opinion?" Dr. Lewis also marked the "no" box in response to Section 5, question 4: 'Was the Physical Requirements of Position/Occupational Title reviewed to make your medical opinion?"

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[2] The Merriam-Webster online medical dictionary defines "myofascial" as relating to the fasciae of muscles.

Medical Records and Reports[3]

MARSHALL LEWIS, M.D.

11. At hearing, respondent submitted several "Primary Treating Physician's Progress Reports" from Marshall Lewis, M.D., with the Pacific Orthopedic Medical Group. The reports are addressed to the State Compensation Insurance Fund and relate to respondent's workers compensation claim.

12. The first report dated October 6, 2006, indicates the respondent was seen for a follow-up regarding her industrial injury that involved her neck, left shoulder, thoracic and lumbar spine. Dr. Lewis performed a physical examination of respondent. Dr. Lewis noted that respondent was not in acute distress. Her cervical spine showed palpable tenderness, with "exquisite tenderness over the left occipital region with frank muscle spasm to the sternocleidomastoid and paraspinous musculature." Examination of the thoracolumbar spine showed diffuse palpable tenderness.

Dr. Lewis noted that respondent was working modified duty. Dr. Lewis did not impose any work restrictions. There is no indication in the report that Dr. Lewis reviewed any written description of respondent's job duties or discussed with respondent what her duties entailed.

13. The second report dated October 18, 2007, indicates that respondent's main complaints "continue to be her neck, shoulder, left upper extremity for numbness and tingling." Dr. Lewis stated that respondent has been seen by the "AME, Dr. Previte, and we have been authorized to proceed with care for this patient based on his 7/14/07 report." Dr. Lewis further stated that Dr. Previte "recommends MRI testing of the cervical spine, MRI testing of the left shoulder, electrodiagnostic study of the cervical spine and left upper extremity."

Dr. Lewis performed a physical examination of respondent which showed "positive impingement sign of the left shoulder, palpable tenderness over the acromioclaicular joint, palpable tenderness over the superolateral aspect of the shoulder and rotator cuff, gross rotator cuff weakness..." Dr. Lewis noted that some degenerative disc disease was seen on a September 22, 2006, x-ray.

Examination of respondent's left elbow showed "palpable tenderness around the epicondyle with frank muscle tightness in the extensor muscle of the forearm and reproducible symptomatology of pain to the lateral epicondyle during forced supination."

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[3] Medical reports from William Previte, D.O., Charles Lewis III, M.D., Marshall Lewis, M.D., and Shahrokh Ilbeigi, M.D. were submitted at hearing by respondent and received into evidence. No treating physicians or medical experts testified at the hearing on this matter.

Dr. Lewis noted that respondent "...will continue to be on a full duty work status." Dr. Lewis did not impose any work restrictions. There is no indication in the report that Dr. Lewis reviewed any written description of respondent's job duties or discussed with respondent what her duties entailed.

14. The final report from Dr. Lewis dated November 29, 2007, indicates that respondent returned for a "follow-up regarding her neck, left shoulder and left upper extremity." Dr. Lewis noted that the "physical examination is unchanged." There was palpable tenderness in the cervical spine, paraspinous musculature and left shoulder. Tinel's test was positive in the wrist, although Dr. Lewis did not indicate which wrist.

Dr. Lewis noted that respondent "...continues to work." Dr. Lewis did not impose any work restrictions. There is no indication in the report that Dr. Lewis reviewed any written description of respondent's job duties or discussed with respondent what her duties entailed.

WILLIAM J. PREVITE, D.O.

15. At hearing, respondent submitted an Orthopaedic Agreed Medical Evaluation (AME) report from William J. Previte, D.O., Orthopaedic Surgeon with the S.P.O.R.T Institute Medical Group Inc., dated July 14, 2007. The AME report is addressed to the State Compensation Insurance Fund and relates to respondent's workers compensation claim. Respondent was seen by Dr. Previte on June 14, 2007. Respondent's chief complaints were: (1) neck pain; (2) mid back pain; (3) low back pain; and (4) rib pain.

Dr. Previte obtained information from respondent concerning the November 29, 2005, assault. Respondent reported that after she returned to work in June 2006, she performed modified duty, but "does not involve herself in any type of containment" and that she was "assisted by others when reaching for large charges and she does not attempt to lift or carry heavy objects."

The AME report lists a history of treatment, review of medical records, and a description of respondent's job duties. Dr. Previte conducted an orthopedic examination of respondent and made the following diagnosis:

(1) Assault, industrial by history, 11/29/05, resulting in cervical strain superimposed upon asymptomatic pre-existing mild cervical degenerative disc disease, left shoulder strain with impingement syndrome, possible left upper extremity radiculitis radiating from her neck, left lateral epicondylitis, and rib fracture, left 8th.

(2) Low back strain, by history, work related, 11/29/05, resolved.

Under the section "Disability Status," Dr. Previte stated that respondent performed modified duties, and was "able to function with avoidance of containments and limitation of

lifting and carrying of objects weighing no greater than 10 lbs." Dr. Previte further stated that respondent "should not be performing forceful pushing/pulling activities or repetitive overhead work with her left upper extremity." Dr. Previte noted that respondent is right-hand dominate.

Dr. Previte recommended MRI testing of respondent's cervical spine and left shoulder. In addition, he recommended electrodiagnostic studies of the cervical spine and left upper extremity "...by way of EMG and nerve conduction velocity studies to determine if there is double crush syndrome, a cervical radiculopathy or a peripheral nerve entrapment disorder that exists in association with the overall symptoms and findings present in her left upper extremity." Dr. Previte stated that respondent may require injection techniques "about the left elbow, as well, possibly even an MRI of the left elbow at some point in the future." Dr. Previte did not recommend any evaluation or treatment of respondent's low back.

16. On October 24, 2008, Dr. Previte conducted an "Orthopaedic AME Re-Evaluation" and issued a report. Dr. Previte stated that respondent continued modified duty until August 2008, when she underwent right shoulder surgery, related to a non-industrial injury. As of the date of the re-evaluation, respondent had not returned to work.

Dr. Previte noted that on October 31, 2007, an MRI of respondent's cervical spine, BAK Imaging indicated "mild congenital central stenosis most marked at the inferior cervical spine region. Moderate degenerative disc and endplate hypertrophic changes are present resulting in mild central and up to moderate foraminal stenosis."

The MRI left shoulder, BAK Imaging impression was "mild subacromial ligament hypertrophy, moderate AC joint degenerative changes and minimal subacromial fluid noted. No other significant findings without rotator cuff tear seen."

Dr. Previte noted that the October 31, 2007, report of electrodiagnostic studies conducted by Stephen Helvie, M.D., found "compatible with minimal carpal tunnel syndrome on the left; left ulnar nerve study is normal; EMG testing of the left upper extremity and hand are normal. No evidence of either acute or chronic cervical radiculopathy."

Dr. Previte precluded respondent from forceful use of the left upper extremity below, at or above shoulder level, as well as from repetitive overhead work and from working in environments in which there could "potentially occur altercations or violence."

17. On November 14, 2009, Dr. Previte conducted an "Orthopaedic AME Re-Evaluation" of respondent and issued a report. Respondent informed Dr. Previte that after she was released to return to work following her right should rotator cuff repair surgery, she attempted to return to work in a modified capacity, but was unable to perform her job duties. Respondent told Dr. Previte that she "retired medically" in July 2009.

Dr. Previte conducted a physical examination of respondent. When Dr. Previte conducted a grip test on respondent, he noted that the left upper extremity grip force could not be considered valid for rating impairment because respondent did not appear to "exert valid effort on grip attempts..."

Dr. Previte diagnosed respondent:

(1) Assault, industrial, with cervical strain aggravating pre-existing cervical degenerative disc disease and left extremity radiculitis, left shoulder strain with impingement syndrome and left lateral epicondylitis.[4]

(2) Rib fracture, left 8th, healed.

(3) Low back strain, industrial, 11/29/05, resolved.

(4) Rotator cuff disease, right shoulder, non-industrial surgically treated, with residuals.

18. There was no finding by Dr. Previte in any of the AME reports that respondent was permanently disabled or incapacitated on the basis of orthopedic conditions from performance of her duties as a PT with the Department.

CHARLES LEWIS III, M.D.

19. Respondent submitted medical records related to her treatment by Charles Lewis III, M.D, Sports Medicine Orthopaedics with the San Joaquin Accident and Medical Group Inc. Dr. Lewis first evaluated respondent on March 27, 2009. Dr. Lewis obtained a history of respondent's injury and her physical complaints, which included moderate to constant neck pain, mid and low back pain, and left shoulder pain. Dr. Lewis reviewed the October 31, 2007, MRI and diagnostic tests performed on respondent. He also performed a physical examination. Dr. Lewis diagnosed respondent with following orthopedic conditions:

(1) cervical, thoracic, and lumbar sprain/strain.

(2) cervical, thoracic and lumbar myofascial syndrome.

(3) left shoulder pain, sprain/strain.

(4) shoulder impingement syndrome.

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[4] The Merriam-Webster online medical dictionary defines "epicondylitis" as "inflammation of an epicondyle or of adjacent tissues--compare tennis elbow."

Dr. Lewis noted that respondent was working. Dr. Lewis did not impose any work restrictions on respondent. There is no indication in the report that Dr. Lewis reviewed any written description of respondent's job duties or discussed with respondent what her duties entailed. Dr. Lewis referred respondent for a pain management consultation, and provided medication and a home exercise program.

20. Dr. Lewis evaluated respondent on April 24, 2009. Respondent's physical complaints were unchanged from the March 27, 2009 visit. Dr. Lewis conducted a physical examination of respondent. His diagnosis was unchanged from the March 27, 2009, visit.

Dr. Lewis noted that he reviewed Dr. Previte's October 24, 2008 AME report. Dr. Lewis concluded that respondent was "temporarily partially disabled and precluded from forceful use of the left upper extremity below, at or above shoulder levels, as well as from repetitive overhead work." Dr. Lewis also precluded respondent from "working in environments in which there could potentially occur altercations or violence." There is no indication in the report that Dr. Lewis reviewed any written description of respondent's job duties or discussed with respondent what her duties entailed.

21. Dr. Lewis evaluated respondent on 11 occasions from April 24, 2009, until September 14, 2010, and issued reports. Respondent's work restrictions remained unchanged. There is no indication in any of the reports that Dr. Lewis reviewed any written description of respondent's job duties or discussed with respondent what her duties entailed. As of the final report dated September 14, 2010, Dr. Lewis diagnosis of respondent's orthopedic conditions remained unchanged from his initial diagnosis on March 27, 2009, with the exception of the additional diagnosis of left cervical radiculitis.[5]

SHAHROKH ILBEIGI, M.D.

22. Dr. Charles Lewis referred respondent to Shahrokh Ilbeigi, M.D. with the California Pain Management Institute, for a consultation that occurred on or about April 29, 2009. Dr. Ilbeigi prepared a report concerning his evaluation of respondent. After taking a history and conducting a physical examination, he diagnosed respondent with the following orthopedic conditions:

(1) spinal stenosis in the cervical region.

(2) other affections of the shoulder region, not elsewhere classified.

23. Dr. Ilbeigi recommended that respondent continue with her prescribed medication, start another medication, obtain trigger point injections and intra-articular steroid injection in the left shoulder, and engage in home cervical and lumbar exercises.

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[5] The Merriam-Webster online medical dictionary defines radiculitis as "inflammation of a nerve root."

24. There is no indication in the report that Dr. Ilbeigi reviewed any written description of respondent's job duties or discussed with respondent what her duties entailed. Dr. Ilbeigi did not recommend any restrictions on respondent's activities, nor did he find that respondent was permanently disabled or incapacitated on the basis of orthopedic conditions from performance of her duties as a PT with the Department.

Independent Medical Evaluation

25. On April 2, 2010, at the request of CalPERS, Ernest B. Miller, M.D. conducted an independent orthopedic medical evaluation (IME) of respondent and thereafter prepared a report.[6] Dr. Miller obtained his medical degree in 1974 from the University of Maryland, Baltimore, and became certified by the American Board of Orthopaedic Surgery in 1982. Dr. Miller maintains an orthopedic surgery practice in San Luis Obispo, California.

26. As part of the IME of respondent, Dr. Miller interviewed respondent, obtained a personal and medical history, conducted a physical examination, and reviewed respondent's medical records related to her orthopedic conditions.

RESPONDENT'S COMPLAINTS AND PHYSICAL EXAMINATION

27. Respondent provided Dr. Miller information about the November 29, 2005, assault and the injuries she sustained. She informed Dr. Miller that she was diagnosed with impinged nerve damage in the left shoulder, a fractured rib on the left side of the chest, and muscle strain. Respondent informed Dr. Miller that she was off work for two months following the assault.

28. Respondent informed Dr. Miller that her symptoms and complaints included: (1) migraine headaches; (2) neck pain in the trapezius muscle which she rated as "ten out of ten;" (3) constant left should pain that she rated as "ten out of ten;" (4) numbness and tingling in both arms and all fingers of both hands; (5) pain in the left side of her chest, which she described as constant and severe; (6) insomnia due to pain; and (7) a bone spur in her right shoulder on the rotator cuff which is affecting her activities of daily living.

29. Dr. Miller conducted a physical examination of respondent. Dr. Miller noted that during the examination, respondent was "emotionally charged and tearful. Dr. Miller further noted that "animation and gesturing is fluid and almost hyperactive in both upper extremities."

Dr. Miller noted a tender defect in the right acromio-clavicular joint, with no tenderness in the left acromio-clavicular joint. The range of motion of the shoulders was symmetric bilaterally. Palpation noted mild crepitation in the shoulders bilaterally.

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[6] Dr. Miller's report was received into evidence at hearing. Dr. Miller did not testify.

Adson's Maneuver, Phalen's Maneuver, Tinel's Sign, and Finkelstein's Test were all negative bilaterally.

The neurological examination demonstrated that respondent's tendon reflexes were "brisk and symmetric bilaterally at the biceps, triceps, and brachioradialis." Respondent's grip strength in her left hand was reduced, with a complaint of pain in the left extremity.

REVIEW OF MEDICAL RECORDS

30. Dr. Miller reviewed respondent's medical records related to her orthopedic conditions from Dr. Mark Matthews, Dr. Marshall Lewis, Dr. Charles Lewis, and Dr. Previte. Dr. Miller noted that the medical records he reviewed began with a report from Dr. Matthews dated November 29, 2005, regarding respondent's injuries from the work-related assault. Dr. Matthews made an initial diagnosis of rib contusion, lumbar strain, and scratches on the left forearm.

31. On January 19, 2006, Dr. Matthews made a diagnosis of fracture of the eighth rib on the left and a left trapezial muscle strain. He recommended physical therapy and encouraged respondent to walk. Dr. Matthews returned respondent to limited duty work, with restrictions that included no overtime, no lifting greater than 25 pounds, and no client containment.

32. Dr. Miller noted that by February 16, 2006, Dr. Matthews returned respondent to full duty. From January 2006 through May 2006, respondent complained of intermittent pain and soreness in the left side of her chest and left upper back. She also complained of intermittent pain in her left forearm and intermittent tingling in her left forearm and hand. Dr. Miller noted that on May 9, 2006, Dr. Matthews ordered an MRI of respondent's cervical spine.

33. Dr. Miller also reviewed a September 22, 2006, report written by Dr. Lewis. Dr. Miller states that Dr. Lewis "...obtains numerous x-ray studies and makes multiple, unsubstantiated diagnoses, including impingement of the left shoulder, acromio-clavicular cartilage disorder of the left shoulder, degenerative disc disease of the cervical spine, cervical strain, thoracic strain, fracture of the left eighth rib, contusion of the left shoulder, scratches on the left forearm, and lumbosacral strain."

34. Dr. Miller noted that an MRI study of respondent's left shoulder performed on October 31, 2007, noted some arthritic change of the acromio-clavicular joint, with no findings of a rotator cuff tear. An MRI study of the cervical spine obtained the same date demonstrates some congenital canal stenosis in the cervical spine with degenerative disc disease of the cervical spine.

35. The electrical diagnostic studies of respondent's left wrist and upper extremities, dated October 31, 2007, noted some minimal carpal tunnel syndrome in the left wrist. There was no evidence of cervical radiculopathy or other nerve entrapment. Dr.

Miller noted that "Dr. Lewis and Dr. Previte continued treatment for inexplicable reasons of multiple diagnoses which are not confirmed on their physical examination or laboratory studies."

DIAGNOSIS AND OPINION

36. Dr. Miller diagnosed respondent with:

(1) Status post-subacromial surgery of the right shoulder;

(2) fracture of the eighth rib of the left chest – resolved;

(3) scratches on the left forearm-resolved;

(4) trapezial muscle strain – resolved; and

(5) generalized, global symptoms and complaints in the left upper extremity are noted to be excessive, disproportionate, and inconsistent with the physical examination and laboratory studies.

37. In response to the question posed by CalPERS to Dr. Miller concerning whether there were specific job duties that respondent was unable to perform because of a physical or mental condition, Dr. Miller answered "No." In addition, Dr. Miller also answered "No" to the question of whether respondent was "substantially incapacitated for the performance of her usual duties."

Respondent's Testimony

38. Respondent testified that after the assault, she continued to work, but she could not perform the duties required on the forensic side of the hospital. Respondent explained that she felt that she could no longer lift clients. Respondent stated that she suffered from pain on her left arm and migraines which became increasingly worse. Respondent explained that Dr. Lewis precluded her from working in volatile situations or containments, because he did not want her to sustain further injury.

Testimony of Marilyn Higgins

39. Respondent's roommate Marilyn Higgins testified at hearing that she has known respondent for over 40 years and has lived with respondent for the last five years. Ms. Higgin's also worked as a PT at Porterville, although she did not work in the same unit as respondent.

40. Ms. Higgins explained that she often takes respondent to her doctors' appointments and that she has observed respondent in pain since the assault in 2005. Ms. Higgins explained that respondent would not try to lift anything over 50 pounds because she

is injured. Ms. Higgins' understanding of respondent's physical limitations is based upon information provided to her by respondent.

Discussion

41. When all the evidence is considered, Dr. Miller's opinion that respondent is not substantially incapacitated for the performance of her duties as a PT based upon her orthopedic conditions is persuasive. Dr. Lewis's contrary opinion is not supported by the evidence. First, Dr. Lewis failed to review respondent's duties as a PT for the Department, or consider the physical requirements for the position in forming his opinion. Furthermore, on September 14, 2010, Dr. Lewis indicated that respondent was only "temporary partially disabled" with restrictions from forceful use of the left upper extremity below, at or above shoulder levels, as well as from repetitive overhead work. Respondent failed to present sufficient evidence that even with the restrictions imposed by Dr. Lewis, she is substantially incapacitated for the performance of her duties as a PT. Furthermore, respondent's restriction from "working in environments in which there could potentially occur altercations or violence" is designed to prevent further injury and is not based on any current disability.

Additionally, none of the medical records from William Previte, D.O., Marshall Lewis, M.D., and Shahrokh Ilbeigi, M.D, that respondent submitted contradict Dr. Miller's opinion that respondent is not substantially incapacitated for the performance of her duties as a PT.

Respondent failed to present competent medical evidence to support her assertion that she is substantially incapacitated for the performance of her usual duties as a PT based upon the legal criteria applicable in this matter. Consequently, respondent failed to establish that her disability retirement application should be granted based upon her orthopedic conditions.

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 his or her duties..." (Gov. Code, § 21156, subd. (a)(1).) As defined in Government Code section 20026,

> "Disability" and "incapacity for performance of duty" as a basis of retirement, mean disability of permanent or extended and uncertain duration, as determined by the board ... **on the basis of competent medical opinion.** (Bolding added.)

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." (Italics in original.)

The employee in *Mansperger* was a game warden with peace officer status. His duties included patrolling specified areas to prevent violations and apprehend violators, issuing warnings and serving citations, and serving warrants and making arrests. He suffered an injury to his right arm while arresting a suspect. He could shoot a gun, drive a car, swim, row a boat, pick up a bucket of clams, pilot a boat, and apprehend. However he could not lift heavy weights or carry a prisoner away. The court noted that "although the need for physical arrests do occur in petitioner's job, they are not a common occurrence for a fish and game warden." (*Mansperger, supra,* 6 Cal.App.3d at p. 877.) Similarly, the need for him to lift a heavy object alone was determined to be a remote occurrence. (*Ibid.)* In holding that the game warden was not incapacitated for the performance of his duties, the *Mansperger* court noted that the activities he was unable to perform were not common occurrences and that he could otherwise "substantially carry out the normal duties of a fish and game warden." (*Id.* at p. 876.)

4. The court in *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 855, reached a similar conclusion with respect to a state traffic sergeant employed by the CHP. 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, supra*, 77 Cal.App.3d at p. 863.) As the court explained, 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. (*Ibid.*)

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 for 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."

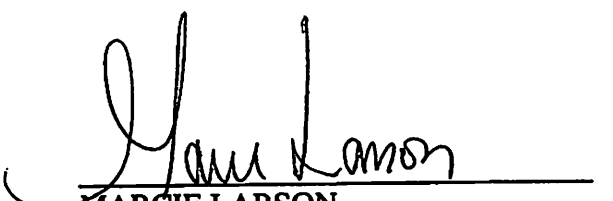
6. The burden of proof is on respondent to demonstrate that she is permanently and substantially unable to perform her usual duties such that she is permanently disabled. (*Harmon v. Board of Retirement of San Mateo County* (1976) 62 Cal. App. 3d 689; *Glover v. Board of Retirement* (1980) 214 Cal. App. 3d 1327, 1332.) To meet this burden, respondent must submit competent, objective medical evidence to establish that, at the time of application, she was permanently disabled or incapacitated from performing the usual duties of her position. (See *Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697.)

7. When all the evidence in is considered in light of the courts' holdings in *Mansperger, Hosford,* and *Harmon*, respondent did not establish that her disability retirement application should be granted. Although respondent complained that working as a PT caused her pain, that she did not believe that she could lift patients, and that a containment situation could cause her further injury, there was not sufficient evidence based upon competent medical opinion that she is permanently and substantially incapacitated for the performance of the usual duties of her job, based on her orthopedic conditions. Consequently, her disability retirement application must be denied.

ORDER

Respondent's application for industrial disability retirement is DENIED.

DATED: December 31, 2013



MARCIE LARSON
Administrative Law Judge
Office of Administrative Hearings