

**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  
Disability Retirement of:

MEINERT C. TOBERER,

Respondent,

and

DEPARTMENT OF VETERANS  
AFFAIRS, YOUNTVILLE VETERANS  
HOME,

Respondent.

Case No. 2014-0518

OAH No. 2014080992

**PROPOSED DECISION**

This matter was heard before Erin R. Koch-Goodman, Administrative Law Judge, Office of Administrative Hearings, State of California, on August 19, 2015, in Sacramento, California.

The California Public Employees' Retirement System (CalPERS) was represented by Jean-Laurie Ainsworth, Senior Staff Counsel.

Meinert C. Toberer (respondent) was present and represented himself.

Evidence was received, the record was closed, and the matter was submitted for decision on August 19, 2015.

Following the close of hearing, the undersigned conducted a review of the CalPERS documentary evidence binder. It was discovered that CalPERS failed to mark or move its jurisdictional documents for admission during hearing. On August 19, 2015, an Order Reopening the Record was issued providing respondent an opportunity to file an objection to the admission of CalPERS' jurisdictional documents by September 2, 2015. CalPERS had until September 9, 2015, to file a reply to respondent's objection. Neither party filed papers. CalPERS Exhibits 1 through 5 were admitted for jurisdictional purposes. The record was

then closed and the matter was submitted for decision on September 10, 2015.

### FACTUAL FINDINGS

1. Anthony Suine, Chief, Benefit Services Division, CalPERS, made and filed the Statement of Issues in his official capacity.

2. Respondent was employed by the Department of Veterans Affairs (DVA), Yountville Veterans Home, as a Health and Safety Officer (HSO) at the time that he filed his application for disability retirement. By virtue of his employment, respondent is a state miscellaneous member of CalPERS, subject to Government Code section 21150.

3. On December 19, 2011, respondent signed his application for service pending disability retirement. In filing the application, disability was claimed on the basis of orthopedic (low back and knees) and neurologic (peripheral neuropathy) conditions.

4. Respondent retired for service effective September 30, 2011, and has been receiving his retirement allowance from that date.

5. Respondent released his medical file to CalPERS. After review of respondent's medical file, concerning respondent's orthopedic and neurologic conditions, CalPERS determined that respondent's conditions were not disabling; and that respondent was not substantially incapacitated from the performance of his job duties as an HSO with DVA. By letter dated September 11, 2013, CalPERS notified respondent of its decision to deny his application for disability retirement and advised him of his appeal rights. Respondent filed an appeal on October 7, 2013.

6. The appeal is limited to the issue of whether, at the time of the application, respondent was permanently disabled or substantially incapacitated from performance of his usual and customary duties as an HSO for DVA on the basis of orthopedic (low back and knees) and neurologic (peripheral neuropathy) conditions.

#### *Job Duties*

7. Respondent began work as an HSO at Yountville Veterans Home in 2005. Taken from the DVA, Yountville Veterans Home, HSO Duty Statement, the HSO develops, plans, implements, coordinates, and evaluates the facility's Health and Safety Program. Program coordination includes injury prevention to meet the specific needs of the facility, identification of unsafe practices/conditions, providing advice to Veterans Home management concerning safety standards, management of the hazardous materials program, and management of the emergency operations plan, as well as chair the Safety Committee, the Emergency Preparedness Committee, and manage the Workers' Compensation Benefits Program. In addition, the HSO develops methods to maintain compliance with Environmental Health and Safety Standards set forth in Titles 8, 17, 19, 22, 26, and 27 of the

California Code of Regulations; and plans, organizes, develops, and conducts health and safety training for managers, supervisors, and staff.

Respondent testified that his job duties included daily inspections of the facility, including walking on uneven ground, climbing stairs, bending and squatting. Respondent explained that his duties required him to: view access areas, maintain medication security, ensure proper storage of chemicals, secure paths for emergency operation plans; as well as ensure compliance with State and Federal laws for health, safety, and maintenance of the facility.

8. Taken from the CalPERS Physical Requirements of Position/Occupational Title form, Yountville Veterans Home provided the following information about the physical requirements of the HSO position.

- a. The position will never require running, crawling, lifting/carrying 26 to 50 pounds, 51 to 75 pounds, 76 to 100 pounds, or 100 plus pounds, working with heavy equipment, exposure to excessive noise, working at heights, or operation of foot controls or repetitive movement.
- b. Occasional tasks, up to three hours a day, could include: standing, walking, kneeling, climbing, squatting, bending neck or waist, twisting neck or waist, reaching above or below the shoulder, pushing and pulling, fine manipulation, power grasping, simple grasping, lifting 0 to 10 or 11 to 25 pounds, exposure to extreme temperature – humidity and wetness, exposure to dust, gas, fumes, or chemicals, use of special visual or auditory protective equipment, or working with bio-hazards (e.g. blood borne pathogens, sewage, hospital waste, etc.).
- c. Frequent tasks, for three to six hours of the day, could include: sitting, repetitive use of hands, keyboard use, mouse use, walking on uneven ground, and driving.

### *Respondent's Medical History*

9. Currently, respondent complains of a constant throbbing pain down the front of both legs from the hips to the ankles, with no pain along the back of the legs. On the outside of the left hip, respondent complains of sharp twinges of pain and sensitivity to the bottoms of his feet. He has had treatment for his knees, including a left anterior cruciate ligament repair surgery and two arthroscopic "clean-out" procedures on his left knee, in the 1980's, and a total left knee replacement (total knee arthroplasty) on November 18, 2010. Respondent reported that he injured his low back with two falls: in 2004, he slipped and fell on ice, landing on his glutinous maximus; and on or about March 21, 2009, while in Alabama for emergency preparedness training for his DVA position, he slipped and fell backwards while in the shower, hitting his low back on the bathtub edge.

10. Respondent testified that he is unable to do the essential functions of his job as an HSO due to pain and numbness in his legs and low back, his inability to walk on uneven ground throughout the Yountville Veterans Home, climb stairs, and bend, kneel, or squat. Respondent last worked at the Yountville Veterans Home on September 30, 2011.

### *Medical Evidence*

11. CalPERS retained two doctors to evaluate respondent. Dr. Gerald Barnes, an orthopedic surgeon, was retained to evaluate respondent's orthopedic condition. Dr. Barnes completed an orthopedic assessment of respondent and reported his findings in an Independent Medical Examination (IME) report. Dr. Barnes determined that respondent was not substantially incapacitated because of his orthopedic conditions.

Dr. Robert Ansel, a neurologist, was retained to evaluate respondent's neurologic condition. However, Dr. Ansel completed an assessment of respondent's overall health, orthopedic and neurological, and reported his findings in an IME report. Dr. Ansel determined that respondent's overall health precluded him from his job duties.

CalPERS then solicited a Supplemental Report from each doctor. CalPERS asked Dr. Barnes to respond to Dr. Ansel's IME findings. Via his Supplemental report, Dr. Barnes concluded that Dr. Ansel was incorrect regarding his determination of respondent's orthopedic condition.

CalPERS asked Dr. Ansel to focus himself solely on respondent's neurologic condition and make a finding regarding whether respondent was substantially incapacitated from his job duties because of his neurologic condition alone. Dr. Ansel concluded that peripheral neuropathy alone did not make respondent substantially incapacitated.

Both doctors testified at hearing. Respondent did not offer any medical evidence, oral or documentary, at hearing.

### **ORTHOPEDIC CONDITION – DR. GERALD C. BARNES**

12. Dr. Barnes saw respondent on March 15, 2013, for examination. Dr. Barnes interviewed respondent, asked respondent questions about his chief complaints, past/present medical problems, medication, and family/social history. Dr. Barnes also reviewed respondent's medical and non-medical (e.g. job duty statement) records. Finally, Dr. Barnes completed a physical examination of respondent.

13. In reviewing respondent's medical records, Dr. Barnes discovered several relevant low back radiological studies. For his back, respondent's medical records revealed three x-rays. On March 30, 2009, respondent had x-rays of his lumbar spine and was diagnosed with hypertrophic changes, including posterior facets lumbar spine and disc space narrowing at L1/L2, L2/L3, and L3/L4. On May 21, 2012, respondent's x-rays of the lumbosacral spine were interpreted as showing retrolisthesis, degenerative disc disease at

several upper lumbar levels, and lower lumbar facet arthropathy. On February 7, 2013, respondent had an MRI of his lumbar spine, interpreted as: multilevel degenerative changes, including a minimal L1 compression fracture; retrolisthesis at L1 on L2 and L2 on L3; disc bulges at several levels, including L3/4, and L4/5; broad disc protrusions, moderate narrowing at the foramen, and degenerative changes of the facet joints, moderate to marked severity. At all times, respondent has been treated with pain medication for his back pain.

For his knees, respondent had three x-rays. On January 9, 2008, respondent had an x-ray of his knees that showed lateral compartment narrowing bilaterally and an indication of a bone screw in the left proximal tibia consistent with previous anterior cruciate ligament repair.

On July 26, 2010, respondent's knee x-ray was interpreted as minor degenerative changes of lateral compartments bilaterally and hardware present at the left proximal tibia. On April 19, 2012, an x-ray of the right knee showed mild patellofemoral osteoarthritis. For treatment, respondent had injections of triamcinolone and lidocaine into his left knee on October 1, 2010, and on November 18, 2010, respondent had a left total knee replacement.

14. During the physical examination, Dr. Barnes found respondent to have full range of motion in his neck and upper extremities. In a seated position, Dr. Barnes found respondent to have limited rotation at the knees. The left knee rotation measured 25 to 136 degrees and the right knee rotation measured 10 to 120 degrees; normal range of motion for the knee is zero to 150 degrees. Dr. Barnes found no tenderness in the joints and full range of motion in the ankles; no particular sciatic nerve radiation; and good reflex tests. Dr. Barnes noted some hypoesthesia on tactile sensory testing about the feet and legs, which would fall in line with respondent's diagnosis of diabetic neuropathy. Dr. Barnes also indicated that respondent accomplished heel and toe walking well.

Dr. Barnes asked respondent to lie on his back, keep his legs straight, and raise them one at a time. Respondent complained of low back pain when each leg reached 45 degrees. Respondent was able to accomplish total hip flexion, extension, and rotation, with some resistance and complaints of pain. Respondent was able to bend forward from a standing position to 90 degrees before he expressed pain. He completed side bends to 30 degrees before complaining of low back pain.

15. Dr. Barnes's IME cited a note chart note by respondent's primary care provider, Dr. Robert Kaer: on December 23, 2011, "[t]he patient is currently substantially incapacitated from performance of his usual duties; this is permanent in nature." Dr. Barnes notes that Dr. Kaer stated in a CalPERS Report on Disability, "because of his [respondent's] left thigh pain, burning low back pain, right knee pain, left knee pain, meralgia paresthetica, diabetic neuropathy in the feet, 'he is currently substantially incapacitated from performing his usual duties and this is permanent in nature.'"

16. The following are Dr. Barnes's diagnostic impressions of respondent:

- (1) Osteoarthritis of the knees with pain;
- (2) Chronic Obstructive Pulmonary Disease (COPD);

- (3) Hypertension under treatment;
- (4) Diabetes mellitus type II under treatment;
- (5) Diabetic neuropathy;
- (6) Asthma;
- (7) Obesity;
- (8) Low back pain secondary to lumbar degenerative disc disease and facet arthropathy;
- (9) Possibility of more recent compression fracture of L1;
- (10) Osteopenia by bone density studies;
- (11) Depression;
- (12) Sleep apnea;
- (13) Suspect opiate dependency.

17. Dr. Barnes concluded that: “[a]fter reviewing his job description, from an orthopedic standpoint, I believe that he could perform with some difficulty his job requirements. However, his cognitive skills that are required on his job, may be affected because of his use of opiates for pain and resultant depression. I would defer comment on any disability questions relative to cognitive issues to a psychiatrist.” “It would be my professional opinion, on an orthopedic basis, that he [respondent] should not be considered substantially incapacitated for the performance of his usual duties considering the physical requirements.”

#### NEUROLOGIC CONDITION – DR. ROBERT ANSEL

18. Dr. Ansel saw respondent on April 25, 2013, for examination. Dr. Ansel interviewed respondent, reviewed respondent’s medical and non-medical (e.g. job duty statement) records, and then completed a physical examination of respondent.

19. A review of respondent’s medical records revealed several diagnoses (e.g. degenerative disk disease in the lumbar spine with significant facet arthropathy, abdominal stenosis and spondylolisthesis, multi-level disk extrusion and protrusion, and a compression fracture on L1, asthma, hypertension, and diabetes) and the details of ongoing care and treatment of respondent, including participation in a chronic pain management program and multiple medications, like long and short-acting opiates. Dr. Ansel’s IME cited several notes charted by respondent’s primary care provider, Dr. Kaer, including: on December 23, 2011, respondent had multiple sources of pain, requiring substantial amounts of medication, which precluded his ability to crawl, bend, kneel, sit and carry heavy loads, as well as his long acting opiates resulted in difficulty in cognition; pain management will most likely be required indefinitely/lifetime; in September 2011, respondent was officially disabled due to his pain; and has become progressively worse throughout the years.

20. In the physical examination, Dr. Ansel observed respondent’s gait as antalgic, favoring his left lower extremity, and his left knee was swollen, acknowledging that he had a total knee replacement. For the spinal examination, Dr. Ansel documented significant discomfort with limited mobility in the lumbar spine to all movements: flexion/extension was

40 degrees and 20 degrees and right/left lateral bending was 15 degrees and 15 degrees. Respondent's lower extremities demonstrated absent tendon reflexes at the knees and ankles, with substantial decrease in proprioception, including all modalities (i.e. pin, touch, temperature) below the knee. His feet demonstrated excellent pulses and were not swollen. The upper extremities were unremarkable.

21. The following are Dr. Ansel's diagnostic impressions of respondent:

- (1) Chronic low back pain secondary to multi-level degenerative arthritis, disk protrusion and recent compression fracture;
- (2) Diabetes with peripheral neuropathy;
- (3) Status post total knee replacement;
- (4) Arterial hypertension;
- (5) Obesity;
- (6) Sleep apnea.

22. Dr. Ansel concluded that respondent is unable to perform his job duties because of his physical condition. "Yes, Mr. Toberer's physical condition would preclude him from repetitive walking, prolonged walking, walking over uneven ground, bending, crouching, crawling, and lifting." In his professional opinion, Dr. Ansel said "yes," respondent is substantially incapacitated for performing his usual duties since "February 2011" and his incapacity is "permanent."

#### SUPPLEMENTAL REPORTS

23. At hearing, CalPERS argued that Dr. Ansel was only retained to evaluate respondent's neurologic condition, and was not qualified to make a medical determination regarding his orthopedic condition. As such, CalPERS requested Dr. Ansel draft a Supplemental Report, where he would only address respondent's neurologic condition. Via his Supplemental Report, Dr. Ansel opined that respondent "does have some degree of peripheral neuropathy which, although symptomatic, in and of itself would not incapacitate him from performing his usual duties as a Health and Safety Officer. The diabetes and secondary neuropathy, in and of themselves, are contributing factors to his disability; however, as noted, his major impairment and limitations leading to his disability are secondary to diagnosis 1, i.e. referable to lumbar spine."

24. So too, CalPERS asked Dr. Barnes to draft a Supplemental Report, evaluating Dr. Ansel's IME findings. Via his Supplemental Report, Dr. Barnes discounted Dr. Ansel's conclusions, because: (1) he is a neurologist, not an expert in orthopedics, like himself; and (2) his orthopedic findings are not supported by the evidence. Dr. Barnes states that: Dr. Ansel did "a very inadequate objective examination of a knee on which to base an opinion..." especially the opinion that respondent was substantially incapacitated from his job duties because of his knee. Dr. Barnes noted that Dr. Ansel's entire physical examination of respondent's knee was scant, recorded in his IME as: "his knee is swollen, acknowledging that he had a total knee replacement." Dr. Barnes opined that total knee replacement allows



for less pain and greater movement, not less, and a swollen knee exposes nothing about possible limitations. In addition, Dr. Barnes notes that respondent admitted to him that he could walk 6/10 of a mile a day after his total knee replacement. Furthermore, Dr. Barnes takes issue with Dr. Ansel's findings, especially "status post total knee replacement." According to Dr. Barnes, without any pathology, or subjective or objective factors, the diagnosis is meaningless and cannot be used as a basis for determining "substantial incapacity." In conclusion, Dr. Barnes reiterated his IME findings, concluding that a "diagnosis, osteoarthritis of the knee with pain – is in itself not a reason to declare someone substantially incapacitated."

### *Discussion*

25. Dr. Ansel testified consistent with his Supplemental Report. He focused on respondent's neurological condition. He was informative, but his medical opinion was incomplete because he was not permitted to expand upon the effect and interplay between respondent's conditions. In comparison, Dr. Ansel's IME is comprehensive and assumes respondent's overall health.

26. Dr. Barnes testified consistent with his IME and Supplemental Report. However, his testimony raised several concerns: relevance, objectivity, and completeness. At hearing, Dr. Barnes declared: "I'm not sure what substantially incapacitated means;" which renders his findings, allegedly made using the substantially incapacitated standard required by the Public Employees Retirement Law (PERL), functionally meaningless. When asked about Dr. Ansel's IME findings, Dr. Barnes flippantly dismissed them as "wrong [and] bad," leaving his objectivity in question. Similarly, Dr. Barnes cites, but neglects to refute or adopt Dr. Kaer's assessments of respondent's medical conditions; making Dr. Barnes's assessments of respondent seem incomplete. Finally, Dr. Barnes's conclusion suggests that respondent should also be evaluated by a psychiatrist "because his cognitive skills that are required on this job, may be affected because of his use of opiates for pain and the resultant depression." However, CalPERS did not refer respondent to a psychiatrist for evaluation and assessment; undoubtedly because respondent did not identify a mental condition on his application. That said, Dr. Barnes's suggestion illuminates the interplay between mental and physical conditions and their treatments; and begs for an overall assessment of respondent, and not one done piecemeal.

27. In this case, Dr. Kaer made the only overall assessment of respondent. Interestingly, Dr. Ansel's IME report is consistent with Dr. Kaer's assessment of respondent; and CalPERS argues that Dr. Ansel's IME report should be disregarded.

Ultimately, Dr. Kaer's medical opinion is competent and reliable. Both Dr. Barnes and Dr. Ansel cite to Dr. Kaer's chart notes and rely on his diagnosis of respondent to render their opinions. Dr. Kaer evaluated both respondent's orthopedic and neurologic conditions and his medications, their interactions and overall effects on respondent. Dr. Kaer concluded that "[respondent] has been officially disabled due to his pain since September 2011." On December 23, 2011, Dr. Kaer verified the following on a CalPERS Report on Disability:

“[respondent] has multiple sources of chronic pain, requiring substantial amounts of medication, which preclude his ability to crawl, bend, kneel, sit, and carry heavy loads, as well as his long-acting opiates result in difficulty with cognition.” Dr. Kaer concluded: the patient is currently substantially incapacitated from performance of his usual duties. Dr. Kaer determined that respondent’s condition is “permanent in nature.” Dr. Kaer’s opinion is persuasive and subsumes both Dr. Barnes’s and Dr. Ansel’s reports.

28. For all the above reasons, respondent has established through competent medical evidence that his combined orthopedic (low back and knees) and neurologic (peripheral neuropathy) conditions, together, substantially disable him from performing his regular duties as a HSO at Yountville Veterans Home.

## LEGAL CONCLUSIONS

### *Applicable Laws and Statutes*

1. In determining whether a member is eligible to retire for disability, the board shall make a determination on the basis of competent medical opinion. (Gov. Code, § 21156, subd. (a)(2).) Disability as a basis of retirement, means disability of permanent or extended and uncertain duration. (Gov. Code, § 20026.)

2. A member incapacitated for the performance of duty shall be retired for disability pursuant to this chapter if he or she is credited with five years of state service, regardless of age, unless the person has elected to become subject to section 21076 or 21077. (Gov. Code, § 21151, subd. (a).) Applicants must demonstrate their substantial inability to perform their usual duties on the basis of competent medical evidence. (*Mansperger v. Public Employees’ Retirement System* (1970) 6 Cal.App.3d 873, 876.) Mere difficulty in performing certain tasks is not enough to support a finding of disability. (*Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854.)

3. According to Government Code section 21154, “[o]n receipt of an application for disability retirement of a member, the board 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.”

4. If the medical examination and other available information show to the satisfaction of the board, that the member in the state service is incapacitated physically or mentally for the performance of his duties and is eligible to retire for disability, the board shall immediately retire him for disability. (Gov. Code, § 21156, subd. (a)(1).)

### *Determination*

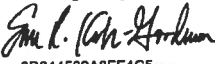
5. Cause exists to grant respondent’s application for disability retirement within the meaning of Government Code sections 21151, 21156, and applicable case law.

Competent medical evidence established that respondent is permanently disabled or incapacitated from the performance of his duties as an HSO on the basis of his orthopedic and neurological conditions. (Factual Findings 12 through 28.) Dr. Kaer's medical opinion was competent, reliable, and complete. Dr. Kaer's opinion is also persuasive and subsumes both Dr. Barnes' and Dr. Ansel's reports. He applied the CalPERS standard of substantial incapacity and determined that respondent is disabled; and that respondent cannot perform the essential functions of his job. In other words, respondent is precluded from performing his usual duties as an OHS with the DVA at the Yountville Veteran's Home.

#### ORDER

The application of Meinert C. Toberer for PERS Disability Retirement is  
GRANTED.

DATED: October 9, 2015

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ERIN R. KOCH-GOODMAN  
Administrative Law Judge  
Office of Administrative Hearings