ATTACHMENT A

THE PROPOSED DECISION

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

In the Matter of the Reinstatement from Industrial Disability Retirement of:	Case No. 2015-0529
SHELLY LOZANO,	OAH No. 2015090075
Respondent,	
and	
WASCO STATE PRISON, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION,	
Respondent.	

PROPOSED DECISION

This matter was heard before Jonathan Lew, Administrative Law Judge, Office of Administrative Hearings, on May 10, 2016, in Fresno, California.

Kevin Kreutz, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Andrew Shorb, Attorney at Law, represented Shelly Lozano (respondent), who was present.

There was no appearance by, or on behalf of, Wasco State Prison, California Department of Corrections and Rehabilitation (CDCR).[1]

Evidence was received, the hearing concluded, and the record was held open until June 10, 2016, for filing of written closing arguments. Respondent's and CalPERS's briefs were filed respectively on June 9 and 10, 2016, and marked as Exhibits H and 18 for

[1] Compliance with service requirements under Government Code sections 11504 and 11509 was established. With respect to Wasco State Prison, CDCR, this matter proceeded by way of default under Government Code section 11520.

identification. The record was closed, and the matter was submitted for decision on June 10, 2016.

ISSUE

Does respondent remain substantially incapacitated, on the basis of an orthopedic (back) condition, from the performance of her duties as a Correctional Officer for Wasco State Prison, CDCR?

FACTUAL FINDINGS

1. Respondent was employed by CDCR as a Correctional Officer at Wasco State Prison. By virtue of her employment, she is a state safety member of CalPERS subject to Government Code section 21151.[2]

2. On February 21, 2002, respondent filed with CalPERS an application for industrial disability retirement on the basis of an orthopedic (back) condition arising from an industrial accident that occurred on February 15, 1998.

3. On July 16, 2002, CalPERS approved respondent's application for industrial disability retirement. She was placed on the industrial disability roll effective December 31, 2001, and has been receiving her retirement allowance from that date.

Duties of a Correctional Officer

4. As set forth in a Correctional Officer Job Analysis (Job Analysis), Correctional Officers "are sworn Public Safety Officers and must be qualified under the California Penal Code in the use of firearms and other areas relating to a sworn position." They "provide security to inmates in correctional institutions in accordance with established polices, regulations and procedures, and observe conduct and behavior of inmates to prevent disturbances and escapes." There are many different posts to which Correctional Officers may be assigned to work in a correctional institution. Correctional Officers "must be able to perform the duties of all the various posts."

The Job Analysis states that Correctional Officers must be able to: (a) lift and carry 20 to 50 pounds frequently (from one-third to two-thirds of the work day); (b) lift and carry over 100 pounds occasionally (one-third or less of the work day); (c) physically restrain, lift

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[2] Government Code section 21151, subdivision (a), states: "Any 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."

and carry an inmate;[3] (d) occasionally run, climb, crawl and crouch; and (e) twisting of the body frequently to continuously throughout the work day. With regarding to twisting of the body, the Job Analysis noted:

> Correctional Officers must have overall body flexibility as well as be able to twist their body in all directions while performing their regular duties. Twisting may take place with the body in an upright position while either standing or walking. Twisting the body in awkward positions while bending over to conduct an inmate body search or cell search in a cramped space. Twisting of the body in different directions may occur during altercations or while restraining inmates. Twisting of the body may take place very rapidly and without warning.

Correctional Officers must be able to crawl or crouch under an inmate's bed or restroom facility while involved in cell searches. They must be able to crouch while firing a weapon or while involved in property searches. They must be able to stoop and bend while inspecting cells, physically searching inmates from head to toe.

2002 Independent Medical Evaluation (IME) by Mark Nystrom, M.D.

5. After receiving respondent's disability retirement application, CalPERS sent respondent for an IME to Mark Nystrom, M.D., a board-certified orthopedic surgeon. Dr. Nystrom physically examined respondent, reviewed her history, medical records and job duties, and issued an IME report dated May 13, 2002. At the time, respondent was 33 years old. Respondent told Dr. Fischer that on February 15, 1998, she slipped in some water and fell backwards, twisting and catching herself with her hands. She experienced low back pain, underwent conservative treatment and then returned to work without restrictions. At the time she was examined by Dr. Nystrom, respondent described gradual pain with constant back discomfort and radiation to her bilateral legs.

6. After examining respondent and reviewing her medical records and job duties, Dr. Nystrom diagnosed respondent as follows: 1) Lumbar stenosis; and 2) Left-sided radiculopathy due to small herniated disc.

Dr. Nystrom noted subjective factors as pain that was "moderate in intensity and intermittent in frequency." Objective factors included an abnormal MRI and radicular pain consistent with MRI. He believed at that time that respondent had reached a maximum level of benefit from supervised medical treatment, and that her condition was permanent. Dr. Nystrom opined that respondent was "substantially incapacitated from her current

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[3] The Job Analysis indicates: "Correctional Officers must be able to drag/carry an inmate out of a cell. Correctional officers must be able to perform lifting/carrying activities while working in very cramped space."

occupation." He had reviewed respondent's Job Analysis and noted that she was "unable to do any running or climbing. Searching cells requires crawling, crouching, stooping, and bending that she cannot do. She cannot carry or restrain an inmate." Dr. Nystrom opined that respondent was unable to perform the usual and customary duties of her position without restrictions.

7. As noted in Finding 3, CalPERS approved respondent's application for industrial disability retirement. She was placed on the industrial disability roll effective December 31, 2001, and has been receiving her retirement allowance from that date

July 29, 2009 IME by Alice Martinson, M.D.

8. In 2009, CalPERS referred respondent to Alice Martinson, M.D. for an IME. Dr. Martinson is a board-certified orthopedic surgeon. On July 29, 2009, Dr. Martinson physically examined respondent, reviewed her history, medical records and job duties, and issued an IME report. Respondent complained of frequent lower lumbar back discomfort with intermittent exacerbations which radiated down into her right leg as far as her ankle. She reported occasional discomfort in her left leg, and her symptoms were made worse by sitting longer than 15 to 20 minutes. Respondent also reported that she had been working from 2003 to 2008 as a part time merchandiser for an electronics company.

Dr. Martinson reviewed an MRI of respondent's lumbar spine performed in January 2009. Dr. Martinson noted that the MRI showed "disruption of the posterior annulus at L4-5, containing a small amount of bright signal nuclear material, producing a small bulge into the spinal canal eccentric to the right. There is no significant central or lateral recess stenosis at the L4-5 level or at any other levels. She has some mild loss of disc hydration at L5-S1, but the left-sided disc protrusion described in her AME of 2001 is no longer present." Dr. Martinson did not find the imaging findings to be "particularly dramatic" but indicated that they were "concordant with her complaints and have been present for more than ten years."

9. Dr. Martinson diagnosed respondent as follows: "Discogenic low back pain with no evidence of radiculopathy." She opined that respondent was substantially incapacitated from the performance of her duties as a Correctional Officer, and that her incapacity was permanent. Dr. Martinson explained:

> As a consequence of her low back condition, she is unable to perform the frequent bending, twisting, lifting, and carrying requirements of the position. She is also, in my opinion, incapable of performing the unpredictable, highly exertional efforts that might be required to defend herself and fellow officers from inmate assault.

10. After Dr. Martinson's IME, respondent remained on disability retirement.

February 19, 2015 IME by Ghol B. Ha'Eri, M.D.

11. In 2015, CalPERS sent respondent for an IME with Ghol B. Ha'Eri, M.D., a board-certified orthopedic surgeon. Dr. Ha'Eri is also a Diplomate, American Academy of Neurological and Orthopedic Surgery. He has practiced over 47 years as an orthopedic surgeon. Dr. Ha'Eri has performed IMEs for CalPERS for approximately three years, and has performed disability evaluations in matters involving correctional officers approximately 50 times.

12. On January 27, 2015, Dr. Ha'Eri physically examined respondent, reviewed her history, medical records, surveillance video and job duties, and issued an IME report. At the time of this IME, respondent was 46 years old. Respondent complained of consistent slight lower back pain with radiation to the legs, right more than left, and a numb feeling in her right leg. Dr. Ha'Eri noted that respondent was under the primary care of Alan Moelleken, M.D., an orthopedic surgeon, who had referred her for an MRI of the lumbar spine twice and for electrodiagnostic study of her lower extremities. Respondent had also received lumbar epidural steroid injections twice from Michael Kenly, M.D., a pain management specialist.

13. On physical examination, Dr. Ha'Eri noted that respondent had a normal posture and gait, and her lower back showed normal lumbar lordosis. Palpation of the lumbosacral region revealed mild tenderness. No paravertebral muscle spasm was noted. Range of motion of her back was measured based on active voluntary flexion and extension, as well lateral flexion/rotation. It showed limited motion ranging from 20 to 30 degrees of normal. Dr. Ha'Eri found that neurological examination of the lower extremities (sensory, motor, reflexes) were grossly intact. Circumferential measurements of her lower extremities were equal, left and right.

14. After examining respondent and reviewing her medical records, MRI studies and job duties, Dr. Ha'Eri diagnosed her as follows: "Mild degenerative disc changes and spondylosis at L4-5 level."

15. Dr. Ha'Eri opined that respondent was not substantially incapacitated from performing her usual duties as a Correctional Officer. Dr. Ha'Eri stated in his IME report:

> There are no specific job duties which I feel that the member is unable to perform because of the physical condition of her lower back. The MRI study of the lumbar spine shows mild degenerative changes at the L4-5 level as well as mild spondylosis at L4-5. A more recent MRI study of the lumbar spine dated June 19, 2012 shows L4-5 disc dehydration and a 3 millimeter concentric disc bulge at this level associated with mild facet hypertrophy. The viewed/reports of surveillance performed by the investigators as well as myself did not show that the claimant is in any distress. She was able to move

around comfortably. I also noted photographs of her riding a jet ski and swimming in a pool.

16. At hearing, Dr. Ha'Eri testified in a manner consistent with his report, elaborating on some of his earlier findings. Dr. Ha'Eri noted that if respondent had been experiencing significant back pain, more guardedness and muscle spasm would be expected and not the mild tenderness on palpation he found. He also indicated that the equal circumferential measurements of her lower extremities was very significant because one would expect muscle atrophy if there were asymmetrical damage over the period between 1998 and 2015. Dr. Ha'Eri explained that the natural history of respondent's condition would allow for desiccation and disc shrinkage over time, causing a natural stabilization/improvement in that area to occur. This would result in a natural relieving of pressure and less disc bulge. He opined that the more recent MRI findings (June 19, 2012) showed L4-5 disc dehydration with a three millimeter concentric bulge. He characterized this as mild degenerative disc disease, something very common in individuals as young as age 50. He opined that this is a naturally occurring condition that has nothing to do with her earlier industrial accident, which he described as a trivial slip and fall that resulted in an aggravated condition that should have been treated and resolved over a two to three-month period. He disagreed with the earlier AME and QME medical reports finding that respondent was disabled.

Dr. Ha'Eri characterized findings related to foraminal narrowing to be common, and not indicative of a pinched nerve. Although respondent had reported a history of radiating pain, he opined that the more recent MRI report provided no objective support for this condition. He believes that there was "plenty of room" in the spinal canal, and that respondent's condition is dynamic and capable of improvement over time.

17. Dr. Ha'Eri found no objective findings that could explain or corroborate respondent's complaints of pain, and does not believe that the mild degenerative changes in her low back area represent anything other than normal degenerative changes one would expect over time.

Evaluation by Alan Moelleken, M.D.,

18. Alan Moelleken, M.D. has followed respondent since 2008. Dr. Moelleken is Board Certified in Orthopedic Surgery, and Spine Fellowship trained in Neurosurgery and Orthopedic Surgery. He specializes in spine surgery. Dr. Moelleken did his orthopedic residency at UCLA, and his combined neurological and orthopedic surgery fellowship at New York University. He currently works at the Spine and Orthopedic Center in Santa Barbara. Dr. Moelleken testified at hearing on behalf of respondent.

19. Dr. Moelleken examined respondent in 2008, at which time she presented with back and bilateral lower extremity symptoms, right worse than left, with weakness in her foot and big toe. He noted back tenderness with limited range of motion. He performed a neurological examination as part of his evaluation. Dr. Moelleken determined that she had

radiculopathy, with pain radiating to her calf and numbness in her toe. He related this to her L-5 nerve, and he noted it was highly suggestive of lumbar radiculopathy with a pinched nerve in her spine.

Dr. Moelleken prepared a Primary Treating Physician's Progress Report dated June 18, 2009. He diagnosed her with degenerative disc disease, herniated nucleus pulposus (HNP) at L4-5, right side, and right-sided L4-5 neuroforaminal narrowing. He found her history, examination and MRI findings all correlated with these diagnoses. At that time he chose conservative treatment, and also recommended transforaminal epidural steroid injections on the right at L4-5. He agreed with other evaluating physicians that respondent could not return to work at that time.

20. Dr. Moelleken evaluated respondent on September 9, 2015. She complained of constant aching back pain, right worse than left. She described radiation of pain, numbness and tingling into her right lower extremity and extending to her toes. She rated her back and leg pain at a 7/10 on the pain scale. Dr. Moelleken reviewed the June 19, 2012 MRI report which indicated the following Impression: "Moderate spondylosis L4-5 with disc dehydration and height loss, formation of a concentric small annulus bulge which has foraminal extension and contributes to moderate foraminal narrowing, right greater than left. Findings are minimally changed comparing to the previous from 2009." Dr. Moelleken diagnosed respondent at that time with HNP lumbar spine, lumbar stenosis and lumbar radiculopathy.

21. At hearing, Dr. Moelleken agreed that disc herniation may improve over time, but emphasized that degenerative disc disease never disappears. In this case, he opined that the 2012 MRI demonstrated deterioration, and not an improvement in respondent's condition. Dr. Moelleken attached special significance to language in the June 19, 2012 MRI report that specified: "As compared to prior MRI, narrowing of the L4-L5 disc has progressed slightly but otherwise findings are stable."

Dr. Moelleken disagreed with Dr. Ha'Eri's conclusion that there was no objective evidence to support respondent having a pinched nerve. Dr. Moelleken examined the actual MRI images, and noted the areas of narrowing of the cervical canal in the area of the L4-5 vertebrae. He opined that the images clearly showed abnormal changes; specifically there is a visible transition from a circular or oval shaped canal above the L4-5 vertebrae, to a more restricted triangular shaped canal at the L4-5 vertebrae. He explained that this abnormality is the result of disc degeneration resulting from injury that compresses respondent's sciatic nerve. Dr. Moelleken also noted that the foraminal narrowing of the canal is clearly evident in both the written MRI report and the actual MRI images. The foraminal narrowing at L4-5 is bilateral so that the nerve root is compressed on both sides. Dr. Moelleken opined that this is objective evidence of lumbar radiculopathy. He noted that he cannot imagine anyone with this condition performing the duties of a correctional officer, such as extracting a 200 pound inmate from a cell. Dr. Moelleken believes Dr. Ha'Eri missed the nerved compression and associated radiculopathy, and that he omitted the lateral recess stenosis and foraminal

narrowing as objective indications of disability. He believes respondent's condition does not merely represent degenerative arthritic changes as suggested by Dr. Ha'Eri.

Testimony of Respondent and Family Members

22. Respondent, her daughter Samantha Lozano, and her husband Sam Lozano all testified to the level of respondent's activities before and after her 1998 accident. Respondent was at one time fairly active, fit and engaged in all manner of daily activities. She ran and attended aerobic classes, coached soccer and engaged in competitive sports including weight lifting and running. Mr. Lozano noted that respondent was the sit-up champion for all academy women. Since her 1998 injury, respondent's most strenuous activity is walking. She participated in a five-kilometer benefit fun-run. Samantha Lozano indicated that respondent was uncomfortable and in pain following this event. Respondent is able to walk in and around stores while shopping, but feels uncomfortable after such activities. She averred that she takes muscle relaxants and Norco to manage the pain after these activities. Respondent rode a jet ski following her injury. She explained that the photograph of her atop a jet ski was a posed still shot, and in shallow water.

Respondent can stand for up to 10 minutes prior to taking a break. She averred that she must take a lot of breaks. She must constantly shift her weight and has difficulty standing for long periods of time. There are periods when she cannot even get out of bed, and she is sometimes down for up to three days. Respondent indicated that she takes Norco daily for pain.

Respondent does not believe that she can run full out while wearing a duty belt and baton in ready position. She does not believe she is physically capable of responding to a yard incident were she to return to duty as a Correctional Officer. She has not worked in a full time capacity over the past three years.

Discussion

23. Dr. Ha'Eri's essentially opined that in the absence of any objective medical findings to support respondent's complaints of pain, she is no longer incapacitated from the performance of her usual duties as a Correctional Officer. He described a normal physical examination, generally normal range of motion, no atrophy of relevant muscle groups, no back spasms and a grossly intact neurological examination. He characterized respondent's MRI findings as demonstrating only mild degenerative changes typical of one her age.

24. Dr. Moelleken, in contrast, identified very specific objective findings from respondent's most recent MRI to support his diagnoses and respondent's subjective complaints. He well explained how these findings lead to compression of her sciatic nerve. The narrowing of the canal about the L4-5 vertebrae is clearly visible on the MRI images, and the foraminal narrowing is evident in both the written MRI report and the actual images. Dr. Moelleken explained the causal connection between respondent's disc degeneration and pinched nerve to her inability to perform a majority of physically demanding tasks required

of correctional officers. His findings are consistent with past examinations by evaluating physicians.

Dr. Moelleken was more persuasive than Dr. Ha'Eri in his conclusion that respondent cannot perform the physical exertion, bending, twisting, stooping, crawling, lifting, carrying, and running required of a Correctional Officer. Dr. Moelleken viewed all 22 minutes of video taken of respondent's activities over a two-day period. He observed nothing that demanded significant physical effort and no "smoking gun."

25. The testimony of Dr. Moelleken is persuasive that objective MRI findings do support respondent's reported symptoms and continuing physical disability. It is also consistent with past medical evaluations of respondent by Dr. Nystrom and Dr. Martinson.

26. Because respondent is already receiving disability retirement, the burden was on CalPERS to establish that respondent is no longer substantially and permanently disabled from performing the usual duties of a Correctional Officer. CalPERS did not present sufficient competent medical evidence to meet its burden of proof. Consequently, its request that respondent be involuntarily reinstated from disability retirement should be denied.

LEGAL CONCLUSIONS

1. In accordance with Government Code section 21192, CalPERS re-evaluates members receiving disability retirement benefits who are under the minimum age for service retirement. That section, in relevant part, provides:

> The board ... may require any recipient of a disability retirement allowance under the minimum age for voluntary retirement for service applicable to members of his or her class to undergo medical examination ... The examination shall be made by a physician or surgeon, appointed by the board... Upon the basis of the examination, the board or the governing body shall determine whether he or she is still incapacitated, physically or mentally, for duty in the state agency ... where he or she was employed and in the position held by him or her when retired for disability, or in a position in the same classification, and for the duties of the position with regard to which he or she has applied for reinstatement from retirement.

2. Government Code section 21193 governs the reinstatement of a recipient of disability retirement who is determined to no longer be substantially incapacitated for duty and, in relevant part, provides:

> If the determination pursuant to Section 21192 is that the recipient is not so incapacitated for duty in the position held

> when retired for disability or in a position in the same classification or in the position with regard to which he or she has applied for reinstatement and his or her employer offers to reinstate that employee, his or her disability retirement allowance shall be canceled immediately, and he or she shall become a member of this system.

3. Government Code section 20026 defines "disability" and "incapacity for performance of duty," and, in relevant part, provides:

> "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.

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.) In *Hosford v. Board of Administration of the Public Employees' Retirement System* (1978) 77 Cal.App.3d 854, 862 the court held that a disability or incapacity must currently exist and that a mere fear of possible future injury which might then cause disability or incapacity was insufficient.

5. To involuntarily reinstate respondent from industrial disability retirement, CalPERS had to establish that respondent is no longer substantially incapacitated from performing the usual duties of a Correctional Officer. As set forth in Findings 23 through 26, CalPERS did not offer sufficient competent medical evidence at the hearing to meet its burden of proof. Consequently, CalPERS' request that respondent be involuntarily reinstated from disability retirement should be denied.

ORDER

The request of California Public Employees' Retirement System to involuntarily reinstate respondent Shelly Lozano from disability retirement is DENIED.

DATED: June 20, 2016

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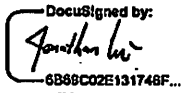
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JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings