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 Industrial Disability Retirement of:

JOHN V. LOPEZ

and

DEPARTMENT OF STATE HOSPITALS, COALINGA SECURE TREATMENT FACILITY,

Respondents.

Case No. 2019-1050

OAH No. 2020010829

PROPOSED DECISION

Administrative Law Judge Regina Brown, State of California, Office of Administrative Hearings, heard this matter remotely on February 22, and June 7, 2021.

Dustin Ingraham, Staff Attorney, represented complainant California Public Employees' Retirement System (CalPERS).

Respondent John V. Lopez represented himself at hearing.

Respondent Department of State Hospitals, Coalinga Secure Treatment Facility (the Department or DSH or Coalinga) was not represented at hearing. The Department was duly served with a Notice of Hearing. The matter proceeded as a default against the Department pursuant to Government Code section 11520, subdivision (a).

The record remained open to allow respondent to file additional documents. On July 8, 2021, respondent filed medical records which were marked for identification as Exhibits B.1-B.40.[1] On August 4, 2021, complainant filed his letter of objections, which was marked for identification only, as Exhibit 11. Exhibits B.1-B.7, B.9-B.11, B.14-B.31, B.32.1, B.33, and B.35-B.40 are admitted into evidence as administrative hearsay. Exhibits B.13 and B.32 are admitted into evidence. Exhibits B.8 and B.12 are excluded from evidence because they are incomplete records.

The record closed and the matter was submitted for decision on August 4, 2021.

FACTUAL FINDINGS

Jurisdictional Matters

1. Respondent John V. Lopez began working for Department of State Hospitals, Coalinga Secure Treatment Facility, as a registered nurse in 2001. By virtue of his employment, he is a safety member of CalPERS subject to Government Code section 21151.

2. On January 30, 2019, respondent signed an industrial disability retirement application with CalPERS based on coccidioidomycosis, otherwise known as

[1] Respondent did not file an Exhibit B.34.

Valley Fever, as the disabling condition. On September 24, 2019, CalPERS issued a letter to respondent indicating that all the medical evidence had been reviewed and CalPERS denied the application for industrial disability retirement because it had determined that respondent's condition was not disabling and he was not substantially incapacitated from performance of his duties as a registered nurse at the time the application was filed.

3. Respondent filed a timely appeal and requested an administrative hearing.

4. On November 15, 2019, Keith Riddle filed the Statement of Issues in his official capacity as Chief of the Benefit Services Division, CalPERS.

Job Duties

5. Respondent's job duties as a registered nurse (safety) included, among other things: providing direct nursing care treatment and rehabilitation to inmate patients, providing direction to other personnel, assisting physicians, and providing general psychiatric care to patients. Respondent administered medications, observed and assessed patients and recorded notes in their medical records. Respondent was also required to perform custody tasks, including supervision of patients, escorting patients in the facility, distributing and inspecting patients' mail for hazardous contraband, performing "take downs" of inmates, and searching for drugs, contraband, or weapons to identify security breaches that could lead to the escape of an inmate. Physical requirements of the position required him to stand, sit, walk, run, lift, carry, and work with biohazards. Respondent worked in a behavioral unit at Coalinga.

Work-Related Injury

6. In May 2009, after working six months at Coalinga, which is located in the San Joaquin Valley, respondent developed a persistent cough, shortness of breath, fever and chills. A CT scan of respondent's chest, taken on May 30, 2009, revealed pneumonia in his left lower lobe and development of a very small pleural effusion (an excessive collection of fluid in the space that surrounds the lungs). He was hospitalized for five days. Respondent was diagnosed with Valley Fever, which is a fungal disease that causes illness in some individuals who inhale fungal spores endemic to the San Joaquin Valley. He was treated with fluconazole, an antifungal agent, for nine months. He was taken off work.

7. During this same period of time, respondent was under the care of his treating physician, Prem Sahasranam, M.D., for uncontrolled diabetes. He was taken off work until October 2009, for his uncontrolled diabetes.

8. On October 14, 2009, Gerald B. Levine, M.D., performed a qualified medical re-evaluation of claimant. Dr. Levine opined that the cause of his disease was unclear, but inconsistent with coccidiomycosis. Dr. Levine believed that it is medically probable that dust exposure in the work setting was the cause of respondent's acute infection. Respondent also would have been more prone to develop the infection given the relative immunosuppression conferred by his preexisting diabetes. Dr. Levine considered respondent to be permanent and stationary and believed that he could return to work with no work restrictions or preclusions. Dr. Levine explained the disease Valley Fever:

> Coccidioides immitis is the fungus responsible for the disease coccidiomycosis. The fungus is endemic to the San

Joaquin Valley. Dust storms have been the primary cause of epidemics. A recent study indicates that the incidence of infection increases when rainy summers are followed by dry winters and windstorms, resulting in enhanced growth and dispersion of arthrospores. The disease is the result of the inhalation of fungal spores. The clinical outcome of exposure depends on the virulence of the organism, the size of the inoculum or antigen load and the immunocompetence of him. Clinical illness follows approximately 40% of exposures to this fungus. Symptoms appear 7-21 days after inhalation of the fungus. For most patients the illness is nondescript and is often mistaken for a viral infection. The most frequent symptoms are dry cough, low-grade fever, and chest pain. They may be followed by severe fatigue. There are 5 main clinical manifestations, acute pneumonia, chronic progressive pneumonia, pulmonary nodules and cavities, extrapulmonary nonmeningeal disease and meningitis. The chest X-ray may show pneumonia. The blood count may show a leukocytosis and/or peripheral eosinophils. A rash may develop either in the form of erythema multiforme or erythema nodosum. Extrapulmonary lesions result from hematogenous spread and include meningitis arthritis and bone and skin lesions. Predisposition to spread of the disease includes immunosuppression, pregnancy and genetic factors in racial groups including Filipinos, African

> Americans, Mexican Americans and Native Americans. The diagnosis is established by the demonstration of positive serology or the presence of the fungus in sputum or tissue. Skin tests will also become positive at some point. Treatment is with antifungal drugs.

9. In February 2010,[2] respondent developed a cough and suffered from fatigue. Manthani P. Reddy, M.D., diagnosed coccidiomycosis and diabetes. He ordered cocci serology and chest X-ray which confirmed a diagnosis of pneumonia. This X-ray revealed, when compared to an earlier X-ray, that there were some residual densities in the left lung base that could represent scarring and possibly recurrent pneumonia. His right lung was clear. His lab result was positive for the presence of Coccidioides Ab antibodies.

10. In April 2011, respondent developed a non-productive cough and low grade fever. Dr. Reddy diagnosed diabetes and pneumonia versus recurrence or relapse of coccidioidomycosis. Dr. Reddy recommended a cocci serology and chest X-ray which revealed stable left lower lobe infiltrate with no demonstrated pleural abnormality.

11. Dr. Sahasranam released respondent to return to work on August 1, 2011.[3] Respondent moved to Minnesota. However, he continued to receive medical care in California.

---

[2] The evidence is unclear if, and when, respondent ever returned to work full duty.

[3] The evidence is unclear if this release was related to his diabetes. His work status is unknown.

12. In November 2012, respondent sought treatment for a cough, fever, and phlegm. Laboratory tests and a chest X-ray were ordered.

11. On December 13, 2012, the University of California, Davis School of Medicine, Coccidioidomycosis Serology Laboratory, determined that respondent was positive for the coccidioidal CR by immunodiffusion, but was favorably negative for complement fixation (the basis of many serologic tests for infection).

12. A CT with contrast of respondent's chest, taken on December 20, 2012, revealed stable circumscribed nodular mass density along the lateral aspect of the left lower lung field with a cavitary component concordant with a previously demonstrated lesion on a chest radiograph taken on May 9, 2011. The appearance was compatible with a benign infectious process.

13. Respondent returned to Minnesota and sought treatment for chills, coughing, congestion, and body aches. On December 30, 2012, respondent was admitted to the hospital by Moti L. Vishwakarma, M.D., with the Mayo Clinic Health System. Respondent was diagnosed with influenza and clinical pneumonia. He was discharged in stable condition on January 2, 2013, with diagnoses of coccidioidomycosis, diabetes mellitus type 1, hyperlipidemia, and hypertension.

14. A high resolution CT of respondent's chest, taken on January 1, 2013, revealed in the left lower lobe a 3 cm cavitary mass peripherally at the pleura, atelectasis and hilar adenopathy. It was recommended to have clinical correlation and comparison with previous studies.

15. An X-ray of respondent's chest taken on January 8, 2013, revealed continued but improving left basal atelectasis/infiltrates and cavitary mass, as

compared to an X-ray taken on December 31, 2012, and the chest CT taken on January 1, 2013.

16. On December 3, 2013, at the request of Dr. Levine, Raymond T. Cummins, M.D., performed a record review of multiple radiological examinations over a three to five year period for indication of Valley Fever in respondent. Dr. Cummins found that the "initial examinations in 2009 demonstrated extensive and dense left lower lobe consolidation with pleural reaction. The inflammatory infiltrate slowly regressed over a 9-month interval to a focal 2 cm nodular mass on 02/23/10. Subsequently, the mass slowly enlarged to a maximum dimension of 4 cm on 01/01/13 and demonstrated central cavitation. The evolution is consistent with a cavitating fungal mass (exampled coccidiomycosis)."

17. On December 12, 2013, Dr. Levine performed a qualified medical re-evaluation based on respondent's episode of pneumonia requiring hospitalization and recurring episodes of bronchitis with no recurrence of Valley Fever. In his report, Dr. Levine noted that respondent continued to be treated for diabetes. Respondent's current laboratory test results excluded an active fungal infection. However, he had the residual effects of the original infection characterized by an increasing cavitary lesion in his lower lobe with possible fungal infestation. Dr. Levine considered respondent to be permanent and stationary. He recommended semi-annual clinical follow-ups with an infectious disease consultant and an annual CT scan to assess possible further increase in size of the lesion or further complications.

18. In a supplemental medical-legal report, dated June 30, 2014, Dr. Levine opined that respondent's underlying diabetes may well have increased his susceptibility to develop the infection.

19. In a supplemental medical-legal report, dated August 19, 2014, Dr. Levine opined:

> The spores of coccidioides may be inhaled by anyone in contact with them. The spores do not attach themselves to diabetic glucose molecules. It is unpredictable whether there will be any change in the nodule. Surgery as a possible option if it became necessary. Because of the diabetes the original infection stood greater chance for dissemination. There remains a chance for reactivation. It is believed that the diabetes probably made it easier to develop the infection. Have previously described apportionment and said this is work-related. Did not feel that an endocrinology opinion would be of help. The poorer control of diabetes [increased] the chance of reactivation. The normal value for hemoglobin A1c depends on the lab and specific test used. Aware of the risk for diabetes or anyone who may be immunosuppressed. It is unlikely, but possible that a reactivation may occur in the form of pneumonia. It is necessary to keep non-occupational diabetes as well controlled as possible. For 45 years, he experienced valley fever. He got only 10% disability when he is type 1 diabetic since 40 years old. He has no psychological impairment. He has evidence of a cavity, which causes no symptoms, but represents an injury. Have identified the appropriate f/u for him, which is all considered occupational. Have stated the answers as the

> level of impairment. He had a high-risk to develop valley fever, because of the diabetes the original infection stood greater chance for dissemination. There remains a chance for reactivation.

20. In January 2017, respondent sought treatment with an unknown medical provider for recent pneumonia and history of Valley Fever.

21. In a note, dated January 5, 2018, Dr. Sahasranam indicated that respondent was seeking to be transferred out of Coalinga because of his Valley Fever.

22. A CT of respondent's chest, taken on March 1, 2018, revealed the presence of a cavitary lesion seen in in the left lower lobe communicating with the bronchiole showing irregular thickening of the wall suggestive of healed granulomatous lesions and most likely related to the prior history of Valley Fever.

23. On March 1, 2018, Omar Tirmizi, M.D., performed a supplemental panel qualified medical evaluation report based on respondent's date of injury of December 22, 2016, for pneumonia. Dr. Tirmizi had previously evaluated respondent in June 2017, and had diagnosed respondent with a remote history of coccidioidomycosis and recurrent pneumonias. Dr. Tirmizi wrote the following:

> Upon review of his PFTs, had diagnosed him as having 12% WPI secondary to respiratory disorders. Had recommended additional testing, which included cocci titers and CT chest. Have now reviewed the provided CT chest as well as blood tests performed on him. The date of the blood test is 01/25/18. This shows that the cocci titers taters, IgG, and IgM are both negative. A CT chest was obtained on

> 03/01/18, which shows that there is a cavitary lesion in the left lower lobe. This represents old healed lesions secondary to Valley Fever. No other lung nodules were noted. Review of records from 12/2016 also indicate that the diagnosis was that of a chronic left lower lobe cavitary lesion with superimposed pneumonia and a history of Valley Fever. He was given empiric fluconazole as well as antibiotics. It is opined that the pneumonia that he was afflicted with, in 12/2016 is not a new injury. In fact, it is not even clear if he truly had coccidioidomycosis. He likely had community-acquired pneumonia in the same location as his previous cavitary lesion. There is no evidence that he had reactivation or a new episode of coccidioidomycosis as his cocci titers remain negative on recent lab testing. Do not see if cocci titers were ever checked in December or January, which is immediately after his acute pneumonia. Records only indicate that he had an acute episode of pneumonia, which is not considered to be either a new injury or reactivation of an old injury.

24. On March 26, 2018, Dr. Sahasranam diagnosed respondent with bronchitis, history of Valley Fever, after having a recent hospital admission with bronchitis. According to Dr. Sahasranam, respondent sought a note stating that he was unable to work. Respondent told the doctor that he planned to retire. In a progress note, dated June 21, 2019, Dr. Sahasranam diagnosed respondent with obesity, diabetes, and Valley Fever. There was no indication of any new testing for Valley Fever.

IME Conducted by Dr. Leonard

25. On August 22, 2019, at CalPERS's request, Thomas Leonard, M.D., conducted an Independent Medical Examiner (IME) examination of respondent and prepared a report.

26. Dr. Leonard is board-certified in Internal Medicine. In 1967, he earned a medical degree from New York Medical College. From 1969 through 1973, he completed his residency at the Public Health Service at University of California, San Francisco, which included a one-year fellowship in cardiopulmonary disease. From 1973 until 1984, Dr. Leonard served as the Critical Care Director, Director of Medical Education and the Medical Director of the emergency room at Vallejo General Hospital. From 1973 until 1996, Dr. Leonard operated a private practice. He has treated many patients with Valley Fever. Since 1993, he has been performing medical evaluations related to respiratory illnesses including Valley Fever.

27. As part of the IME, Dr. Leonard interviewed respondent, obtained a medical history, and conducted a physical examination. He also reviewed the Physical Requirements form, duty statement for respondent's registered nurse position and respondent's available medical records.

28. Dr. Leonard diagnosed respondent with status post coccidioidomycosis pneumonia, insulin-dependent diabetes mellitus, chronic exogeneous obesity, hypertension, and persistent left lower lobe cavitary lesion. Dr. Leonard opined that respondent's illness was industrially related. According to Dr. Leonard, respondent developed a left lower lobe pneumonia diagnosed promptly and treated appropriately. In his follow-up tests, respondent's cocidioidomycosis titers, his antibodies, returned to normal or negative. However, his lower lob nodule became cavitary and appeared

to have stabilized at 4 cm. Dr. Leonard opined that the cavitary lesion is not a cause of symptoms for respondent.

29. Dr. Leonard noted that possibly fear, based on lack of understanding by respondent's treaters of Valley Fever, caused respondent to believe that he can again develop Valley Fever from further exposure. Dr. Leonard described that as an extraordinarily unusual scenario based on the information provided, absent a new pulmonary function study, which would be beneficial.

30. Dr. Leonard testified at the hearing consistent with his reports. Dr. Leonard stated that diabetes has no relation to Valley Fever. Dr. Leonard was only aware of respondent's hospitalization in December 2012 for viral pneumonia and he did not have active Valley Fever at that time.

31. According to Dr. Leonard, respondent's cavity evolved over the years after he developed pneumonia. Respondent's cavity is in the left lower lobe where the pneumonia originated and at the time of his evaluation, it was not causing symptoms and he had recovered from Valley Fever. Dr. Leonard finds it unlikely that the cavity would expand beyond the area of pneumonia. Dr. Leonard noted that Dr. Tirmizi, after his examination of respondent, noted a cavity lesion, but Dr. Tirmizi did not mention that the cavity had increased more than 4 cm. Dr. Leonard posited that if the cavity had increased to 5 cm, this would be concerning to a treater for developing infection in that pocket and it might require surgery. Dr. Leonard also posited that respondent has a history of obesity which can lead to shortness of breath with activity.

32. Dr. Leonard does not believe that respondent is at risk of Valley Fever returning if he were around spores again because respondent has developed an immunity. Dr. Leonard has not seen any cases where an individual has had a second

infection of Valley Fever. Dr. Leonard agreed that, in some cases, if the organism that causes pneumonia is not fully treated, then it may sit quietly and reactivation could occur. However, the blood test reviewed by Dr. Tirmizi showed no organisms in respondent's body, so there was no reactivation. Dr. Leonard stated that he would "never say never, but it is extremely unlikely for reactivation of Valley Fever if respondent returned to the San Joaquin Valley because [he] has developed immunity."

33. Dr. Leonard explained that when a patient is diagnosed with Valley Fever, it is common to test for and follow the complement fixation titers, which is considered to be a marker of level of activity of the disease. Dr. Leonard explained that in some instances a high titer can be concerning because the organism may be disseminating out of the lungs into other tissues. However, respondent's titer levels were positive for several months, but then he was no longer positive. Respondent's coughing is an upper respiratory action and has nothing to do with his left lower lung which is now fully resolved. Dr. Leonard agreed that respondent has sustained scarring in his left lower lung, but again he has fully recovered from Valley Fever.

34. Dr. Leonard opined there is no evidence that respondent suffers from Valley Fever. Dr. Leonard also opined that respondent is not substantially incapacitated from performing his job duties due to Valley Fever.

Respondent's Additional Evidence

35. After the hearing, respondent provided additional medical evidence that primarily duplicated the records that Dr. Leonard reviewed for the IME.

36. In a note, dated April 27, 2021, Dr. Sahasranam wrote that respondent has "a medical condition that puts him at risk for being in Coalinga area. Valley Fever is endemic in Coalinga."

37. Respondent testified that since 2009, he has been hospitalized four times with pneumonia. He would be symptom-free for months at a time, and then he would require treatment for colds, coughs or bronchitis for months at a time. His condition affected his ability to perform his job because he had to respond to alarm system activations and perform takedowns of combative patients, and he would get short of breath. He would also get short of breath when covering the courtyard during windy and rainy days. Respondent states that he has a 7 cm nodule to his left lower lobe with lung damage, the nodule is now the size of a quarter.

38. Respondent stated that he was off work for four years. Respondent described his current symptoms as having limitations with respiratory activities such as playing ball with his children, and getting short of breath and starting to gag when walking. Respondent stated that he still has lung damage, and he can feel it. Dr. Sahasranam told respondent that it was dangerous for him to work in the Coalinga area where he has ongoing coughing and gagging spells. Furthermore, his diabetes places him at higher risk because the Valley Fever "spores like sugar." Respondent just wants to be healthy and live a good life. After he stopped working, he moved to Minnesota where he has had less of any respiratory issues.

39. Respondent testified that, when he initially took the position, his employer did not explain the high risk of contracting Valley Fever through inhaling spores. He described the cases of fellow employees who contracted Valley Fever and he knows of several staff members who have died from Valley Fever. According to respondent, his employer now requires staff to sign a form informing them of the possibility of contracting Valley Fever. Respondent believes that his employer participated in a "cover up" in order to recruit nurses.

Analysis

40. When all the evidence is considered, respondent failed to establish that at the time he filed his application he was permanently disabled or substantially incapacitated from performing the usual duties of a registered nurse for the Department, due to his inactive Valley Fever condition.

41. Although respondent has presented evidence of recurrent pneumonia, coughing, shortness of breath, and fatigue, Dr. Leonard's opinion that respondent does not have active Valley Fever and it is highly unlikely that further exposure will reactivate the Valley Fever is persuasive. Dr. Leonard conducted a physical examination and reviewed respondent's extensive medical records. The evaluation and records support Dr. Leonard's opinion that respondent does not have active Valley Fever. There was also no objective evidence that respondent is not able to perform his job duties due to his inactive Valley Fever.

42. Respondent's assertion that the cavity in his left lower lobe has increased past 4 cm was not supported by the medical evidence.

43. Additionally, neither Dr. Levine nor Dr. Sahasranam provided any opinions supported by objective findings to demonstrate that respondent has active Valley Fever or that further exposure will reactivate Valley Fever in respondent because of his diabetes. Neither did either physician opine that respondent is substantially incapacitated from the performance of his job duties as a registered nurse. Neither Dr. Levine nor Dr. Sahasranam testified at hearing or was available for cross-examination. As a result, their opinions were admitted only as administrative hearsay and cannot be relied upon, standing alone, to support any findings as to respondent's condition. (Gov. Code, § 11513, subd. (d).)

44. Respondent did not present competent medical evidence to support the assertion that at the time he filed his application he was permanently disabled or substantially incapacitated from the performance of his usual and customary duties as a registered nurse based upon the legal criteria applicable in this matter.

LEGAL CONCLUSIONS

1. "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 regardless of age or amount of service." (Gov. Code, § 21151, subd. (a).) The terms "disability" and "incapacitated for performance of duty" as a basis of retirement under the Public Employees' Retirement Law means "disability of permanent or extended duration, which is expected to last at least 12 consecutive months or will result in death . . . on the basis of competent medical opinion." (Gov. Code, § 20026.) To determine whether an applicant is "incapacitated for performance of duty," the courts look to whether the applicant is disabled from performing the substantial range of his or her usual duties. (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876, *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, 859-860.) The member has the burden of proving incapacity. Also, an employee's permanent disability rating under the workers' compensation system is a different issue than whether the employee is capable of performing his usual duties. (*Winn v. Bd. of Pension Commissioners* (1983) 149 Cal.App.3d 532, 539-540.)

2. Applicant has the burden of proof to establish that, at the time of his retirement, he was substantially unable to perform the usual duties of his position as a registered nurse with the Department. He has not met this burden. The only

comprehensive medical evaluation was performed by Dr. Leonard and he concluded that applicant was not precluded from returning to his usual duties. There is insufficient medical evidence to the contrary. Dr. Leonard was persuasive in his testimony that respondent's Valley Fever was inactive and had resolved. Applicant's fear of reactivation of Valley Fever is understandable given some of the medical advice he has received; however, the risk of future injury is not sufficient to establish disability. (*Hosford, supra*, 77 Cal.App.3d at pp. 863-865.)

3. It is undisputed that respondent's Valley Fever condition was industrial. However, this incapacitating condition has resolved. He does continue to suffer from recurrent pneumonia and other respiratory maladies, but the evidence did not establish a connection between these conditions and his inactive Valley Fever condition.

4. When all the evidence is considered, respondent failed to provide persuasive medical opinion to establish that his coccidioidomycosis – Valley Fever condition substantially incapacitated him from the performance of his usual and customary duties as a registered nurse for respondent Department of State Hospitals, Coalinga Secure Treatment Facility. Therefore, respondent is not entitled to retire for industrial disability pursuant to Government Code section 21151, subdivision (a).

5. Cause exists to sustain CalPERS's denial of respondent's disability retirement application.

ORDER

The application of John V. Lopez for CalPERS industrial disability retirement is denied.

DATE:09/01/2021

Regina Brown

REGINA BROWN

Administrative Law Judge

Office of Administrative Hearings