

ATTACHMENT A

THE PROPOSED DECISION

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

In the Matter of the Application for Industrial Disability

Retirement of

DUANE J. WHITCOMB, Respondent

and

**CALIPATRIA STATE PRISON, CALIFORNIA DEPARTMENT OF
CORRECTIONS AND REHABILITATION, Respondent**

Case No. 2019-0316

OAH No. 2019070126

PROPOSED DECISION

Jami A. Teagle-Burgos, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on December 4, 2019, in San Diego, California.

Austa Wakily, Senior Attorney, represented petitioner, Keith Riddle, Chief, Disability and Survivor Benefits Division, Board of Administration, California Public Employees' Retirement System (CalPERS), State of California.

Duane J. Whitcomb, respondent, represented himself.

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM

FILED 1/3 20 20
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There was no appearance by Calipatria State Prison, California Department of Corrections and Rehabilitation (CDCR). Upon proof of compliance with Government Code sections 11504 and 11509, this matter proceeded as a default against Calipatria State Prison, CDCR, pursuant to Government Code section 11520.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on December 4, 2019.

PROTECTIVE ORDER SEALING CONFIDENTIAL RECORDS

Exhibits B through L, which contained Mr. Whitcomb's medical records, were received and contained confidential information. It is impractical to redact the information from these exhibits. To protect his privacy and the confidential personal information from inappropriate disclosure, Exhibits B through L are ordered sealed. This sealing order governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to this order, provided that the documents are protected from release to the public.

ISSUE

At the time of Mr. Whitcomb's application for disability retirement, was he permanently disabled or incapacitated from performing the usual and customary duties of a Correctional Counselor II, Specialist, due to his orthopedic (left elbow, left shoulder, knees, and feet), cardiac (chest pain and hypertension), and internal (diabetes and tingling fingers) conditions?

SUMMARY OF DECISION

Mr. Whitcomb had the burden to prove that, at the time of his application, he was permanently disabled or incapacitated from performing his regular and customary job duties as a Correctional Counselor II, Specialist. The competent medical evidence presented did not support his claim that he was permanently disabled or incapacitated from performing the regular and customary duties of a Correctional Counselor II, Specialist, due to his orthopedic (left elbow, left shoulder, knees, and feet), cardiac (chest pain and hypertension), and internal (diabetes and tingling fingers) conditions. Mr. Whitcomb's claim for disability retirement is denied.

FACTUAL FINDINGS

Preliminary Matters

1. Mr. Whitcomb was employed by Calipatria State Prison, CDCR, as a Correctional Counselor II, Specialist. By virtue of his employment, Mr. Whitcomb was a State safety member of CalPERS subject to Government Code section 21151.

2. On June 1, 2018, Mr. Whitcomb filed an Industrial Disability Retirement Election Application with CalPERS. He retired from service effective June 15, 2018, and has been receiving his retirement allowance since that date. Mr. Whitcomb claimed the right to receive a disability retirement because he suffered cumulative injuries from the date of his hire to the present, and his disability occurred on August 6, 1989, and September 26, 2013. Mr. Whitcomb described that he was injured while changing a tire of a State vehicle. He stated that he was disabled due to chest pain, diabetes, hypertension, tingling fingers, and pain in his shoulder, rotator cuff, and elbow.

3. CalPERS obtained medical records and reports related to Mr. Whitcomb's conditions and selected James Michael Fait, M.D., an orthopedic surgeon, Robert B. Weber, M.D., a cardiologist, and Prema Mona Khanna, M.D., an internist, to perform disability evaluations. Dr. Fait, Dr. Weber, and Dr. Khanna provided CalPERS with narrative reports of their findings and conclusions. After reviewing all of those documents, CalPERS determined that when Mr. Whitcomb filed his application for a disability retirement, he was not permanently disabled or incapacitated from performing the usual and customary duties of a Correctional Counselor II, Specialist.

4. On January 29, 2019, CalPERS notified Mr. Whitcomb that his application for disability retirement was denied. CalPERS advised him of his right to appeal that adverse determination.

5. On February 28, 2019, Mr. Whitcomb timely filed his appeal, and requested an administrative hearing.

6. On June 27, 2019, petitioner filed the statement of issues in his official capacity. The statement of issues, notice of hearing, and other jurisdictional documents were served on all respondents. Calipatria State Prison, CDCR, did not respond to the statement of issues or appear in this matter and the matter proceeded against it as a default.

Job Description Documents

7. The Essential Functions of a Correctional Counselor II, Specialist, and the Physical Requirements of that position outlined the tasks and physical requirements of that position. Dr. Fait, Dr. Weber, and Dr. Khanna relied upon those documents in formulating their opinions.

CalPERS's Medical Evaluations Conducted by Medical Experts

DR. FAIT AND HIS INITIAL AND SUPPLEMENTAL REPORTS AND TESTIMONY

8. Dr. Fait is a board certified orthopedic surgeon, and he received his medical degree from the University of California, Davis. He has a private practice and he has been a provider at Foundation Medical Group, Inc., since 2012. He was previously a provider at Southern California Permanente Medical Group, from 2002 until 2012.

9. On October 15, 2018, Dr. Fait conducted an orthopedic Independent Medical Examination (IME) of Mr. Whitcomb, and prepared an initial report for CalPERS that same day. Dr. Fait noted that his examination included an interview with Mr. Whitcomb where he was asked about his current complaints, relevant history of injuries, past medical history, family and social history, and daily activities. Dr. Fait reviewed a progress report, dated June 21, 2018, by Cyril Gostich, D.P.M., a treating podiatrist from Imperial Valley Podiatry Associates, which indicated, "[Mr. Whitcomb] was seen in follow-up injection from his last visit, saying he is almost 100% better . . . He presents with foot pain . . . [Mr. Whitcomb] arrived ambulating by himself, wearing proper shoes. . . ."

10. Mr. Whitcomb provided the following explanation of the history of his injuries. In 2008, he noted a gradual onset of pain in his left foot, which he attributed to his job duties that required constant walking, standing, and running while wearing State-issued boots. He was seen by his treating podiatrist, Dr. Gostich, who provided treatments of medication, injections, several procedures on his toenails, and bunion surgery on his left foot in 2009, after which he returned to full duty two months later.

In 2013, Mr. Whitcomb noticed a gradual onset of bilateral knee pain, which he attributed to the same job duties, and due to wearing equipment weighing 15 to 20 pounds. He was treated by his primary care physician for his bilateral knee pain, and he was prescribed medication.

In 2014, Mr. Whitcomb was changing a tire on a State vehicle when he pushed down forcefully on a wrench, and he felt a popping and locking sensation with pain in his left shoulder, pain in his left elbow and left hand, and numbness in the fingers of his left hand. He underwent physical therapy, one to two injections in his left shoulder, and he was released from work for four weeks, after which he returned to modified work duty for an unrecalled period of time. He was treated by James E. McSweeney, M.D., a treating orthopedic surgeon, from 2014 and to the present, who administered cortisone injections in his left shoulder and left elbow, and each of these injections resulted in six to nine months of pain relief. He continued to work without any restrictions.

In 2018, Mr. Whitcomb was working and he experienced chest pain. He was taken by ambulance to a hospital where he was diagnosed with high blood pressure, and he was hospitalized overnight. He was taken off work at that time, and he has not returned to work since.

11. Dr. Fait reported that Mr. Whitcomb is married, with three children ranging in ages from 22 to 26. He began working for CDCR on August 6, 1989, in Tehachapi State Prison, and a few years later he transferred to Calipatria State Prison. He last worked on May 24, 2018. He retired on June 15, 2018

12. Dr. Fait performed a physical examination of Mr. Whitcomb, and he diagnosed him with left shoulder rotator cuff tendinitis without evidence of full-

thickness tear, partial tear, or significant tendinopathy, and no evidence of labral tear per magnetic resonance imaging (MRI) on April 5, 2018; left elbow medical epicondylitis and history of ulnar nerve subluxation with reported history of ulnar neuropathy; complaints of bilateral knee pain with evidence of patellofemoral chondromalacia; hallux rigidus, left great toe metatarsophalangeal joint, status-post presumed osteotomy; hallux rigidus, right great toe metatarsophalangeal joint; and left foot second metatarsophalangeal joint enthesopathy.

In regard to Mr. Whitcomb's diagnoses above, Dr. Fait reported that Mr. Whitcomb complained of multiple industrially-related injuries, including injury to his left foot that resulted in surgery in 2009. Dr. Fait presumed this surgery was for a bunion because he appeared to have undergone a first metatarsal distal osteotomy resulting in shortening of the first metatarsal of the left foot. He sought treatment, on and off, for transverse metatarsalgia to the second toe, which was not uncommon after a shortening osteotomy. He developed a form of degenerative arthrosis of the great toe metatarsophalangeal joint. Dr. Fait reported that Mr. Whitcomb had bilateral knee pain, and his examination was consistent with chondromalacia of the patella in both knees. However, he had no evidence of instability of the knees or significant deformity. Dr. Fait noted that Mr. Whitcomb sustained an injury to his left shoulder, left elbow, and left hand when he was changing a tire on a State vehicle. An MRI on April 5, 2018, was essentially unchanged from a prior study. While Dr. Fait found evidence of irritability with percussion over the cubital tunnel of the left elbow, there was no subluxation of the ulnar nerve. Mr. Whitcomb had mild reduction of grip strength on the left side, but there was no indication of atrophy or fasciculations of the left hand. Dr. Fait also wrote that when Mr. Whitcomb experienced acute chest pain and was hospitalized for one night on May 24, 2018, he had been "working at his usual and

customary job duties, essentially with all of the aforementioned diagnoses." He was diagnosed with high blood pressure, and he was removed from work.

13. Based on his findings, Dr. Fait concluded the following:

Overall, in my opinion, the difficulty in this case is the fact that the examinee was working at full duties without specific restrictions, despite carrying a diagnosis of impingement of the left shoulder, possible ulnar neuropathy in the left elbow, patellofemoral chondromalacia in both knees, and chronic transfer metatarsalgia in the left foot second toe with obvious hallux rigidus deformities of both great toes. Despite all these conditions, the examinee was working at full duties without apparent limitations. The inciting factor that necessitated removal from work and ultimate retirement was the acute onset of hypertensive chest pain and was not due to the musculoskeletal conditions, which were of a chronic and long-standing nature. Furthermore, there is no evidence that these musculoskeletal conditions had substantially worsened in the months leading up to the onset of chest pain in May 2018. The MRI of the left shoulder was essentially unchanged without evidence of tears, but progression of inflammation, there was no evidence of worsening of the cubital tunnel syndrome, and no evidence of any acute abnormality of either the right or left foot. Therefore, in my opinion, there is insufficient medical

evidence to indicate that the examinee has a disabling condition from a musculoskeletal standpoint that would represent a substantial incapacity for the return to work.

14. On March 12, 2019, Dr. Fait prepared a supplemental report, which indicated that he reviewed a progress report by Dr. Gostich, dated June 21, 2018, which stated Mr. Whitcomb presented for an injection in his foot, and he was almost 100 percent better, although he continued to have left plantar heel pain. He was able to ambulate on his own, but he was told to stay off his feet as much as possible. Dr. Fait also reviewed a progress note from Family Care Medical Group, dated June 15, 2018, which stated Mr. Whitcomb was hospitalized for severe substernal chest pain and diaphoresis, although an initial cardiac evaluation showed no cardiac abnormality; he had chronic bilateral foot pain for which he could not run; he was diagnosed with type II diabetes; and he was disqualified from work-required duties. In addition, Dr. Fait reviewed a progress note from Family Care Medical Group, dated June 11, 2018, which indicated the same symptoms and conditions, but stated Mr. Whitcomb was able to comply with the physical requirements of his work. Finally, Dr. Fait reviewed a work release form, dated May 26, 2018, by Lorenzo Suarez, M.D.¹, who indicated that Mr. Whitcomb was unable to return to work due to his medical conditions.

Dr. Fait concluded in his supplemental report that it was only after Mr. Whitcomb's hospital admission for hypertensive chest pain that he was taken off work

¹ In his June 1, 2018, Industrial Disability Retirement Election Application, Mr. Whitcomb identified Dr. Suarez as his "treating physician." Dr. Suarez specializes in family medicine and is Mr. Whitcomb's primary care physician.

by his primary care physician. He had otherwise been responding "quite well" to podiatry treatment, and he was able to return to wearing normal footwear. While Dr. Gostich noted that Mr. Whitcomb's occupation contributed to problems with his feet, his foot pain had improved markedly. As such, Dr. Fait made the following conclusion:

Therefore, once again, it remains my opinion that there is insufficient medical evidence that the examinee is substantially incapacitated from the performance of his duties. I note that there are chronic degenerative conditions of both great toes, but no evidence of any acute worsening of this condition that would preclude an ability to perform the essential functions of a correctional officer. While I recognize that the examinee may experience pain and difficulty with running, I cannot find evidence on examination of an objective abnormality that would preclude the ability to run. The range of motion of the great toe MTP joints and lesser toes is sufficient to allow running, which would be required by the occupation of a correctional officer.

15. In addition, Dr. Fait appeared and testified at the hearing, and he reviewed progress notes by Dr. McSweeney, a treating orthopedic surgeon of Mr. Whitcomb. Dr. McSweeney's progress report from 2018 showed no findings of a rotator cuff tear in the left shoulder. Dr. McSweeney's progress report on October 8, 2019, showed impingement syndrome of the left shoulder, but Mr. Whitcomb's range of motion of the left shoulder had improved since Dr. Fait had examined him. Dr. Fait explained that Mr. Whitcomb was noted to have arthritis of a small joint on the top of

his left shoulder, but there was no evidence of a rotator cuff tear. While an MRI of Mr. Whitcomb's left shoulder on April 5, 2018, showed some partial tears on the bursal surface that caused pain, there was no significant dysfunction and no evidence of any full thickness tear. Dr. Fait also commented that while Dr. McSweeney's most recent progress note showed evidence of medial meniscus tear of the bilateral knees and bilateral plantar fasciitis, he had normal range of motion and no irritability of the bilateral meniscus.

Moreover, Dr. Fait testified regarding Dr. Gostich's progress report on June 11, 2018. Dr. Fait stated that while Dr. Gositch opined that Mr. Whitcomb was precluded from lifting more than 25 pounds while walking and running, due to pain in the tendons of his left foot and pain in his left toe, the diagnoses that Dr. Fait found were similar, and Mr. Whitcomb's complaints were subjective and had existed for years. Dr. Fait remarked that none of the objective findings in Dr. Gostich's progress reports were correlated with any diagnostic studies that resulted in Mr. Whitcomb being precluded from his work activities. Dr. Fait also stated that a progress report by Dr. Suarez on June 15, 2018, indicated that Mr. Whitcomb was "currently insubstantially incapacitated, unable to run due to bilateral foot arthritis," and while he agreed with those diagnoses, he did not find any objective medical evidence that Mr. Whitcomb was precluded from his work activities due to those conditions.

DR. WEBER AND HIS REPORT AND TESTIMONY

16. Dr. Weber is a board certified cardiologist, and he received his medical degree from the Medical College of Wisconsin. He has been in private practice since 1979 in the Los Angeles area, and he has affiliations with Southern California Hospital and Cedars-Sinai Medical Center.

17. On November 26, 2018, Dr. Weber conducted a cardiology IME of Mr. Whitcomb, and prepared an initial report for CalPERS that same day. Dr. Weber noted that his examination included an interview with Mr. Whitcomb where he was asked about his current complaints, relevant history of injuries, past medical history, family and social history, and daily activities. Dr. Weber reviewed several medical records of Mr. Whitcomb, including the following:

- A report on disability, dated June 15, 2018, and a progress report, dated May 26, 2018, by Dr. Suarez, which indicated Mr. Whitcomb had an unremarkable cardiac evaluation when he was admitted to the hospital, and he was diagnosed with type 2 diabetes mellitus without complications.
- An initial cardiology consultation, dated May 25, 2018, by Sahaib Tariq, M.D., which indicated Mr. Whitcomb was admitted to the hospital the day before, and his chest pain symptoms had since resolved, and he should be seen for a stress test.
- Progress notes by Richard Fitzsimmons, F.N.P., dated July 5, 2017, July 21, 2017, August 16, 2017, and March 15, 2018, which indicated Mr. Whitcomb was diagnosed with hypogonadism in male, hyperlipidemia, type 2 diabetes mellitus without complications, and mixed hyperlipidemia, and he was told to exercise at least 30 minutes a day.
- Progress notes by Dr. Gostich, dated September 22, 2017, October 5, 2017, October 23, 2017, November 2, 2017, December 21, 2017, January 5, 2018, May 23, 2018, and June 8, 2018, which indicated Mr. Whitcomb was seen for left plantar forefoot pain that was lessened by injections, and he ambulated with full weight-bearing with proper shoes.

- Progress notes by Dr. McSweeney, dated April 23, 2018, and June 1, 2018, which indicated Mr. Whitcomb had complaints of pain in the left anterior shoulder and numbness to the left long ring little fingers, and a nerve conduction study was requested, and he continued to be permanent and stationary.
- An MRI of the left shoulder, by Wade Donald, M.D., dated April 5, 2018, which indicated Mr. Whitcomb had no occult fracture or bony destructive change, minor irregularities and intrinsic signal in the distal supraspinatus tendon that were less pronounced, no evidence of full thickness tear, partial tear or significant tendinopathy, unremarkable biceps labral complex, and no appreciable bursal fluid.
- An emergency department progress note by Anooshirvan Bozorgmehr, M.D., dated May 24, 2018, which indicated Mr. Whitcomb was treated for chest pain, but an echocardiogram showed no evidence of obvious ischemic changes, and he had complete resolution of chest pain after taking aspirin and nitroglycerin, and studies were essentially unremarkable except for mild hyperkalemia.
- A Lexiscan exercise stress test report by Vachaspathi Palakodeti, M.D., dated June 12, 2018, indicating Mr. Whitcomb had normal resting ECG, appropriate heart rate response, normal resting blood pressure response to exercise, no chest pain, no arrhythmias, and no ST changes.
- A nuclear medicine myocardial perfusion study by Jonathan Blevins, M.D., dated June 12, 2018, which showed that Mr. Whitcomb was negative for

fixed reversible myocardial perfusion abnormalities, although he did have a mild decrease in ejection fraction during stress measuring 48 percent.

18. Mr. Whitcomb provided the following explanation of the history of his injuries. While at work on May 24, 2018, "he experienced a sudden burning and pounding in his anterior chest prompting him to present to the emergency room where testing revealed he had no heart damage; however, [*sic*] was found to have high blood pressure." A nuclear heart scan and an echocardiogram were normal, and no further cardiac testing was recommended. Since the episode, he had no recurrence of chest pain or exertional dyspnea, although he had been sedentary and was unable to exercise due to a podiatric condition.

19. Dr. Weber performed a physical examination of Mr. Whitcomb and found Mr. Whitcomb had a regular heart rate and rhythm, but he did have an S4 murmur that was commonly heard in adults and correlated with normal aging on the heart. He had no jugular or venous distention or bruits in the neck, no edema of the extremities, normal pedal pulses bilaterally, and he was grossly normal neurologically. He had lungs that were clear to percussion and auscultation, and oxygen saturation of 97 percent. He had a body mass index (BMI) of 32.14 that correlated with obesity. Dr. Weber diagnosed Mr. Whitcomb with status-post chest pain episode that occurred on May 24, 2018, non-recurrent; negative investigation for coronary artery disease; history of borderline hypertension; type 2 diabetes mellitus; mixed hyperlipidemia; obesity; and hypogonadism.

20. Based on his findings, Dr. Weber concluded that Mr. Whitcomb was not substantially incapacitated for the performance of his job duties, as he had no heart disease; and there were no specific job duties that Mr. Whitcomb could not perform because of a cardiac condition.

21. In addition, Dr. Weber appeared at the hearing and testified. Dr. Weber also reviewed the following medical records of Mr. Whitcomb:

- An echocardiogram, dated April 9, 2019, noted in a progress report by Dr. Tariq, showed Mr. Whitcomb had evidence of left ventricular diastolic dysfunction with a 50 percent ejection fraction, which was an indicator of low-normal that was commonly called "below normal."
- A myocardial perfusion report, dated April 24, 2019, which indicated Mr. Whitcomb had a small area of ischemia that was a reversible defect at the tip of the left ventricle, and normal left ventricular function with a 63 percent ejection fraction, normal left ventricular volume, and no left ventricular abnormality.
- A progress note, dated August 1, 2019, by Dr. Tariq, which indicated Mr. Whitcomb underwent a recent heart catheterization with a mild view scan that showed evidence of non-obstructive coronary artery disease. Dr. Weber stated this diagnosis could be a complete absence of any plaque or there could be some plaque resulting in mild to moderate narrowing in some areas, but it was not sufficient to result in obstruction of blood flow. Mr. Whitcomb was told to discontinue aspirin, continue Atenolol, and begin Lisinopril for essential hypertension.

After reviewing these additional medical records, Dr. Weber concluded, as he had done in his initial report, that Mr. Whitcomb was not substantially incapacitated for the performance of his job duties; and there were no specific job duties that Mr. Whitcomb could not perform because of a physical condition.

DR. KHANNA AND HIS REPORT

22. Dr. Khanna is board certified in internal medicine, occupational medicine, and public health and preventative medicine. He received his medical degree from the University of Illinois. Dr. Khanna has been a primary care and occupational medicine provider and consultant since 1998. He was the Medical Director of Occupational Medicine and Workers' Compensation at Desert Regional Medical Center, from 2015 until 2017. He has been a visiting Clinical Associate Professor at the University of Illinois since 2009, and he has held teaching positions at the University of North Texas, Loma Linda School of Medicine, Johns Hopkins University, and San Diego State University.

23. On December 31, 2018, Dr. Khanna conducted an internal medicine IME of Mr. Whitcomb, and prepared an initial report for CalPERS that same day. Dr. Khanna noted that his examination included an interview with Mr. Whitcomb where he was asked about his current complaints, relevant history of injuries, past medical history, family and social history, and daily activities. Dr. Khanna reviewed several medical records of Mr. Whitcomb, including the following:

- A progress report, dated October 4, 2013, by Edgardo Yutangco, M.D., which indicated Mr. Whitcomb was diagnosed with shoulder pain, rule out rotator cuff tear, frozen shoulder, and lateral epicondylitis on the left side, and an MRI, dated October 18, 2013, which showed small partial tears but no full thickness tear of the left shoulder.
- A progress report, dated November 21, 2013, by Christopher Lai, M.D., a treating orthopedic surgeon, indicated Mr. Whitcomb was seen for acromioclavicular joint arthritis and a partial tear of the rotator cuff on

the left side, and he underwent physical therapy. On February 13, 2014, Dr. Lai administered an injection in the left shoulder, and on August 27, 2014, Dr. Lai ordered an electrodiagnostic study (EMG) to evaluate the ulnar nerve.

- A progress report, dated February 21, 2014, by Sakshi Aggarwal, M.D., indicated that Mr. Whitcomb had minimal aching and intermittent pain in the left shoulder, and his pain had improved significantly with his pain at a level of zero out of 10.
- An EMG study, dated October 8, 2014, by Thomas Teske, M.D., indicated that Mr. Whitcomb had an essentially normal left upper extremity study, as he had only mild reduction of the left median motor response.
- A progress note, dated October 13, 2015, by Dr. McSweeney, indicated that Mr. Whitcomb was seen for pain in his left shoulder and occasional numbness in his left hand and fingers. He was diagnosed with bicipital tendinosis, subacromial bursitis, and impingement syndrome of the left shoulder. Dr. McSweeney administered injections to the left bicipital groove and/or left carpal tunnel on November 17, 2015, November 24, 2015, October 14, 2016, and June 1, 2018. An MRI of Mr. Whitcomb's left shoulder on April 5, 2018, showed minor irregularities, but there were no new findings of the rotator cuff, and no evidence of full thickness tear, partial tear, or significant tendinopathy; and the bilateral bicep labral complex was unremarkable with no appreciable bursal fluid. On April 23, 2018, Dr. McSweeney indicated that Mr. Whitcomb's recommended treatment for his left shoulder was to continue ibuprofen and injections, but no surgery was indicated at the time. On June 1, 2018, Dr.

McSweeney reported that Mr. Whitcomb complained of pain in his left shoulder with overhead reaching, and he had worsening of numbness of the left fingers, decreased pinwheel sensation, and tenderness in the left bicipital groove, for which he was administered an injection.

- Progress notes, dated July 5, 2017 and July 21, 2017, by Nurse Practitioner Fitzsimmons, indicated that Mr. Whitcomb had a normal physical examination, and he had type 2 diabetes mellitus without complications that was treated with Invokamet.
- Progress notes by Dr. Gostich, from October 5, 2017 through June 8, 2018, indicated Mr. Whitcomb was seen for bilateral foot pain that was treated with injections and proper footwear.

24. Dr. Khanna reported that Mr. Whitcomb was independent with his ability to bathe, toilet, groom and dress himself, shop, drive, manage his medications, and talk on the phone; and he was able to walk up and down the stairs, but this caused bilateral knee pain.

25. Dr. Khanna performed a physical examination of Mr. Whitcomb that showed he had regular heart rate and rhythm without murmurs; lungs that were clear to auscultation; grossly normal movement of the elbows, thumbs, and fingers; and grossly normal sensation of the shoulders, elbows, forearms, wrists and hands. Dr. Khanna opined that Mr. Whitcomb had sustained numbness of his left middle, ring, and small fingers, and left-sided ulnar neuropathy stemming from left shoulder and elbow injuries. While Mr. Whitcomb might have had mild entrapment of his median nerve, he had no neuropathies that were substantiated by EMG studies, whereby he had no motor, strength, or sensory deficits that translated into an impairment. He also

continued to work full-time without limitations that could be attributed to clinically impairing left upper extremity neuropathies. Mr. Whitcomb's condition of type 2 diabetes mellitus did not impair his ability to perform his work duties, as he was diagnosed with this condition in 2008, and continued to work full-time, and he was on an exercise program of walking on a treadmill for 30 minutes three or four times a week, and outdoor cycling between 30 and 60 minutes three or four times a week.

26. Based on his findings discussed above, Dr. Khanna concluded that Mr. Whitcomb was not incapacitated substantially or otherwise in the performance of his job duties.

Respondent's Evidence

MEDICAL RECORDS BY TREATING PROVIDERS

27. At the hearing, Mr. Whitcomb submitted medical records from several treating providers, many of which were reviewed prior to the hearing by Dr. Fait, Dr. Weber, and Dr. Khanna, as discussed above. These medical records were from the following providers: Dr. McSweeney, a treating orthopedic surgeon who was associated with Mr. Whitcomb's workers' compensation claim; Athar Ansari, M.D., a treating cardiologist; Dr. Tariq, a treating cardiologist; Veerinder Anand, M.D., a treating orthopedic surgeon who was associated with his workers' compensation claim; Dr. Gostich, a treating podiatrist; Dr. Suarez, a treating primary care physician; Nurse Practitioner Fitzsimmons, a primary care provider; Federico Hernandez, D.P.M., a treating podiatrist; and Dr. Bozorgmehr at the emergency department of Pioneer Memorial Healthcare District.

Mr. Whitcomb also submitted progress notes from William Bugbee, M.D., and Mark Vaz, M.D., treating orthopedic surgeons at Scripps Clinic Torrey Pines Orthopedic

Surgery, who reported on April 12, 2019, that he had a history of left knee pain and instability. An MRI image of the left knee showed a posterior meniscal horn tear with complex horizontal cleavage component; and he was seen for a routine preoperative evaluation prior to undergoing a knee arthroscopy and medial meniscectomy.

In addition, Mr. Whitcomb submitted a report of a cardiac procedure performed on July 23, 2019, by Dr. Ansari, that indicated he underwent a left heart catheterization, selective left and right coronary angiogram, left ventricle angiogram, right iliofemoral angiogram, and percutaneous closure of the right common femoral arteriotomy. Dr. Ansari determined that Mr. Whitcomb's post-procedure cardiac diagnosis was that he had no significant coronary artery disease.

Moreover, Mr. Whitcomb had the opportunity to cross examine Dr. Fait and Dr. Weber, at the hearing, and had them review portions of the medical records that he submitted at the hearing. The testimony by Dr. Fait and Dr. Weber regarding their opinions of these additional progress notes and diagnostic test results is discussed above in Factual Findings 14 and 20.

TESTIMONY OF RESPONDENT, DUANE J. WHITCOMB

28. Mr. Whitcomb testified that he was employed by CDCR for 29 years, and he sustained injuries that were considered to be lifelong injuries. He felt that he was entitled to disability retirement. He had medical conditions that would no longer allow him to work as a correctional officer in the State of California. Calipatria State Prison was two miles in circumference, and his job required him to respond to fights, run across the prison, and wear a stab-resistant vest.

29. Mr. Whitcomb questioned the findings of Dr. Fait, Dr. Weber, and Dr. Khanna. He remarked that his medical records demonstrated that he had coronary

artery disease for which he underwent a recent heart catheterization; he was scheduled to undergo knee surgery; and he was scheduled to have additional podiatry visits. His doctors also told him that he was not able to run or lift over 25 pounds, yet his job description required that he lift up to 100 pounds.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Absent a statutory presumption, an applicant for a disability retirement has the burden of proving by a preponderance of the evidence that he or she is entitled to it. (Glover v. Board of Retirement (1989) 214 Cal.App.3d 1327, 1332.)

Applicable Statutes

2. Government Code section 20026 defines "disability" and "incapacity for performance of duty," for purposes of a retirement, to mean "disability of permanent or extended and uncertain duration" based on "competent medical opinion."

3. Government Code section 21150, subdivision (a), provides that a member who is "incapacitated for the performance of a duty" shall receive a disability retirement. Section 21151, subdivision (a), provides that such incapacitated member shall receive a disability retirement regardless of age or amount of service.

4. Government Code section 21152, provides in part: Application to the board for retirement of a member for disability may be made by:

(a) The head of the office or department in which the member is or was last employed, if the member is a state member other than a university member.

[¶] . . . [¶]

(d) The member or any person in his or her behalf.

5. Government Code section 21154 provides in part:

The application [for disability retirement] shall be made only (a) while the member is in state service, . . . On receipt of an application for disability retirement of a member, other than a local safety member with the exception of a school safety member, the board shall, or of its own motion it 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. On receipt of the application with respect to a local safety member other than a school safety member, the board shall request the governing body of the contracting agency employing the member to make the determination.

6. Government Code section 21156, provides that if the medical evaluation or other evidence demonstrates that an eligible member is incapacitated physically or mentally, then CalPERS shall immediately retire the member for disability. The determination of incapacitation shall be based on competent medical opinion.

7. Government Code section 21166 provides:

If a member is entitled to a different disability retirement allowance according to whether the disability is industrial or nonindustrial and the member claims that the disability as found by the board, or in the case of a local safety member by the

governing body of his or her employer, is industrial and the claim is disputed by the board, or in case of a local safety member by the governing body, . . .the Workers' Compensation Appeals Board, using the same procedure as in workers' compensation hearings, shall determine whether the disability is industrial.

Appellate Authority

8. "Incapacitated" means the applicant for a disability retirement has a substantial inability to perform his or her usual duties. When an applicant can perform his or her customary duties, even though doing so may be difficult or painful, the public employee is not "incapacitated" and does not qualify for a disability retirement. (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873; *Sager v. County of Yuba* (2007) 156 Cal.App.4th 1049, 1057.)

Interplay between CalPERS's Disability Retirement and Workers' Compensation

9. Although the Public Employees' Retirement Law and the Workers' Compensation law are aimed at the same general goals with regard to the welfare of employees and their dependents, they represent distinct legislative schemes. Courts may not assume that the provisions of one apply to the other absent a clear indication from the Legislature. (*Pearl v. W.C.A.B.* (2001) 26 Cal.4th 189, 197.)

10. Receipt of any type of disability in a related workers' compensation proceeding does not establish qualification for a disability retirement. (*Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689; *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854. Workers' compensation appeal board determinations do not apply to industrial disability retirement proceedings. (*English v. Board of*

Administration of the Los Angeles City Employees' Retirement System (1983) 148 Cal. App. 3d 839, 844-845; *Hawpe v. City of Napa* (2004) 120 Cal.App.4th 194, 207.)

11. Generally, a Workers' Compensation Appeals Board proceeding concerns whether the employee suffered *any* job-related injury, and if that injury resulted in some permanent residual loss, the Workers' Compensation Appeals Board awards the employee a permanent disability rating. Retirement boards, on the other hand, focus on a different issue: whether an employee has suffered an injury or disease of such magnitude and nature that he is incapacitated from substantially performing his job responsibilities. Because of the differences in the issues, "[a] finding by the [Workers' Compensation Appeals Board] of permanent disability, which may be partial for the purposes of workers' compensation, does not bind the retirement board on the issue of the employee's incapacity to perform his duties." (*Bianchi v. City of San Diego* (1989) 214 Cal App 3d 563, 567, citations omitted.)

12. Although the schemes of the retirement boards and the Workers' Compensation Appeals Board are independent and serve different functions, their purposes are in harmony rather than in conflict and applying workers' compensation laws by analogy to retirement board cases may be appropriate as it seems clear that the tendency is to view the two bodies of law as compatible rather than the opposite. (*Heaton v. Marin County Employees' Retirement Bd.* (1976) 63 Cal.App.3d 421,428.)

Competent Medical Opinion

13. CalPERS makes its determination whether a member is disabled for retirement purposes based upon "competent medical opinion." That determination is based on the evidence offered to substantiate the member's disability. (*Lazan v.*

County of Riverside (2006) 140 Cal. App. 4th 453, 461, distinguished on other grounds.)

14. Evidence Code section 801 provides:

If a witness is testifying as an expert, his testimony in the form of an opinion is limited to such an opinion as is:

(a) Related to a subject that is sufficiently beyond common experience that the opinion of an expert would assist the trier of fact; and

(b) Based on matter (including his special knowledge, skill, experience, training, and education) perceived by or personally known to the witness or made known to him at or before the hearing, whether or not admissible, that is of a type that reasonably may be relied upon by an expert in forming an opinion upon the subject to which his testimony relates, unless an expert is precluded by law from using such matter as a basis for his opinion.

15. The determinative issue in each case must be whether the witness has sufficient skill or experience in the field so that his testimony would be likely to assist the trier of fact in the search for the truth, and "no hard and fast rule can be laid down which would be applicable in every circumstance." (*Mann v. Cracchiolo* (1985) 38 Cal.3d 18, 37-38.)

16. A properly qualified expert may offer an opinion relating to a subject that is beyond common experience, if that expert's opinion will assist the trier of fact but

the expert's opinion may not be based on assumptions of fact that are without evidentiary support or based on factors that are speculative or conjectural, for then the opinion has no evidentiary value and does not assist the trier of fact. (*Brown v. Ransweiler* (2009) 171 Cal.App.4th 516, 529-530.)

17. Government Code section 11513, subdivision (d), provides in part: "Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions."

18. Unless admissible over objection in civil actions, hearsay evidence shall not be sufficient in itself to support a finding in an administrative proceeding. (*Carl S. v. Commission for Teacher Preparation & Licensing* (1981) 126 Cal.App.3d 365,371.)

19. Hearsay evidence is not competent evidence that can independently support a finding. (*McNary v Department of Motor Vehicles* (1996) 45 Cal.App.4th 688.)

20. Determining both the nature of Mr. Whitcomb's medical condition, and whether that condition incapacitated him from the performance of his duties, is sufficiently beyond common experience that expert testimony is required. Mr. Whitcomb's physicians did not testify or offer written reports, and Mr. Whitcomb's medical records were received as administrative hearsay. Thus, they were only considered to the extent they supplemented and/or explained other non-hearsay evidence.

Evaluation

21. In order to qualify for a disability retirement, Mr. Whitcomb must demonstrate with competent medical opinions that he was permanently disabled or

incapacitated from performing the usual and customary duties of a Correctional Counselor II, Specialist when he filed his application. Dr. Fait, Dr. Weber, and Dr. Khanna concluded that Mr. Whitcomb was not incapacitated from performing his job duties. Mr. Whitcomb offered no competent medical opinions to refute those opinions. Thus, Mr. Whitcomb failed to meet his burden of proof and his application must be denied. Petitioner's determination that he was not permanently disabled or incapacitated from performance of his duties is affirmed.

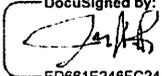
Cause Exists to Deny the Application

22. Cause exists to deny Mr. Whitcomb's application for a disability retirement. Mr. Whitcomb failed to establish by a preponderance of the evidence that he was permanently disabled or incapacitated from performing his usual and customary duties as a Correctional Counselor II, Specialist, for Calipatria State Prison, CDCR, based on orthopedic conditions (left elbow, left shoulder, knees, and feet), cardiac conditions (chest pain and hypertension), and internal conditions (diabetes and tingling fingers), when he filed his application for disability retirement.

ORDER

The application for a disability retirement filed by Duane J. Whitcomb with the California Public Employees' Retirement System on June 21, 2018, is denied. CalPERS's denial of Mr. Whitcomb's application is affirmed.

DATE: January 3, 2020

DocuSigned by:


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Jami A. Teagle-Burgos

Administrative Law Judge

Office of Administrative Hearings