ATTACHMENT B

STAFF'S ARGUMENT

STAFF'S ARGUMENT TO ADOPT THE PROPOSED DECISION, AS MODIFIED

Duane J. Whitcomb (Respondent) was employed as a Correctional Counselor II, Specialist for Respondent Calipatria State Prison, California Department of Corrections and Rehabilitation (Respondent CDCR). By virtue of his employment, Respondent was a state safety member of CalPERS.

Respondent applied for service pending industrial disability retirement based on orthopedic (left elbow, left shoulder, knees and feet), cardiac (chest pain and hypertension) and internal (diabetes and tingling fingers) conditions on June 1, 2018. Respondent retired from service effective June 15, 2018 and has been receiving his retirement allowance since that date.

As part of CalPERS' review of Respondent's medical condition, Robert B. Weber, M.D, a board-certified Cardiologist; James Michael Fait, M.D., a board-certified Orthopedic Surgeon and Prerna Mona Khanna, M.D., a board-certified Internist, performed Independent Medical Examinations (IME). Dr. Weber, Dr. Fait and Dr. Khanna interviewed Respondent, reviewed his work history and job descriptions, obtained a history of his past and present complaints and reviewed his medical records. Drs. Weber, Fait and Khanna opined that Respondent was not substantially incapacitated from performing his job duties as a Correctional Counselor II.

In order to be eligible for disability retirement, competent medical evidence must demonstrate that an individual is substantially incapacitated from performing the usual and customary duties of his or her position. The injury or condition which is the basis of the claimed disability must be permanent or of an extended duration which is expected to last at least 12 consecutive months or will result in death.

After reviewing all of the medical documentation and the IME reports, CalPERS determined that Respondent was not substantially incapacitated from performing the duties of his position.

Respondent appealed this determination and exercised his right to a hearing before an Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH.) A hearing was held on December 4, 2019. Respondent represented himself at the hearing. Respondent CDCR did not appear at the hearing.

Prior to the hearing, CalPERS explained the hearing process to Respondent and the need to support his case with witnesses and documents. CalPERS provided Respondent with a copy of the administrative hearing process pamphlet. CalPERS answered Respondent's questions and clarified how to obtain further information on the process.

CalPERS presented the testimony and IME report of Dr. Weber regarding Respondent's cardiac chest pain and hypertension conditions. Dr. Weber performed a physical examination of Respondent and found that he had a regular heart rate and rhythm, but he did have an S4 murmur that is commonly heard in adults and correlates with normal aging of the heart. Respondent 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. His lungs were clear to percussion, and auscultation and oxygen saturation of 97 percent. He had a body mass index (BMI) of 32.14 which correlated with obesity. Based on his findings, Dr. Weber concluded that Respondent was not substantially incapacitated from the performance of his job duties as he had no heart disease, and there were no specific job duties that he could not perform because of a cardiac condition.

CalPERS presented the testimony and IME reports of Dr. Fait regarding Respondent's orthopedic (left elbow, left shoulder, knees and feet) condition. Dr. Fait testified in a manner consistent with his examination of Respondent and the IME reports.

At the hearing, Dr. Fait testified that during the examination Respondent complained of multiple industrial-related injuries including injury to his left foot that resulted in surgery in 2009. Respondent was seen by his treating podiatrist who provided him treatments by medication, injections, several procedures on his toenails and bunion surgery on his left foot in 2009, after which, Respondent returned to full duty two months post-surgery. Respondent told Dr. Fait that he noticed a gradual onset of bilateral knee pain in 2013 which Respondent attributed to the same job duties, and to wearing equipment weighing 15 to 20 pounds. Respondent was treated by his primary care physician for his bilateral knee pain, and he was prescribed medication.

Respondent described another injury that happened in 2014 while he was changing a tire on a state vehicle. Respondent told Dr. Fait that he pushed down forcefully on a wrench and 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. Respondent 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 unspecified period of time. Respondent was subsequently treated by James E. McSweeney, M.D., a treating Orthopedic Surgeon. Respondent returned to work without restrictions from 2014 until his last date at work in May 2018.

In 2018, Respondent 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.

Dr. Fait's examination of Respondent did not reveal objective evidence to show that Respondent was substantially incapacitated from performing his job duties as a result of an orthopedic condition. Respondent was performing his regular job duties without restriction notwithstanding his prior injuries. Dr. Fait testified that there was no

evidence that Respondent's conditions had worsened such that it impaired his ability to perform his job duties.

Dr. Fait prepared a supplemental report on March 12, 2019, after reviewing a progress report by Respondent's treating physician dated June 21, 2018. The June 2018 report stated that Respondent came in for an injection in his foot, and he was almost 100 percent better, although he continued to have left plantar heel pain.

Dr. Fait reviewed medical reports presented at the hearing, including progress notes by Respondent's treating orthopedic surgeon, James E. McSweeney, M.D. Dr. Fait testified that 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 Respondent's range of motion of the left shoulder had improved since Dr. Fait had examined him. Dr. Fait explained that Respondent 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 a Magnetic Resonance Imaging (MRI) of Respondent'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 tearing of the bilateral knees and bilateral plantar fasciitis, he had normal range of motion and no irritability of the bilateral meniscus.

Dr. Fait testified that it was only after Respondent's hospital admission for hypertensive chest pain that he was taken off work by his primary care physician. There was no objective evidence that Respondent was substantially incapacitated from performing his duties based on an orthopedic condition.

Finally, CalPERS presented the IME report of Dr. Khanna regarding Respondent's internal (diabetes and tingling fingers) condition. Dr. Khanna conducted an IME of Respondent on December 31, 2018 and prepared a report the same day, summarizing his findings upon examination.

Dr. Khanna's physical examination of Respondent showed that he had a regular heart rate and rhythm without murmurs, lungs were clear to auscultation, normal movement of the elbows, thumbs and fingers and normal sensation of the shoulders, elbows, forearms, wrists and hands. Dr. Khanna opined that Respondent had sustained numbness of his left middle, ring and small fingers and left-sided ulnar neuropathy stemming from left shoulder and elbow injuries. While Respondent might have had mild entrapment of his median nerve, he had no neuropathies that were substantiated by EMG studies or sensory deficits that translated into an impairment. Respondent also continued to work full time without limitations that could be attributed to clinically impairing left upper extremity neuropathies. Respondent's 2008 diagnosis of type 2 diabetes mellitus did not impair his ability to perform his work duties. Additionally, 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.

Dr. Khanna concluded that Respondent was not substantially, or otherwise, incapacitated from the performance of his job duties.

Respondent testified on his own behalf. Respondent testified that he was employed by CDCR for 29 years, and he sustained injuries that he considered to be lifelong. Respondent testified that he felt that he was entitled to disability retirement because his medical conditions preclude him from responding to fights, running across the prison and wearing a stab-resistant vest. Respondent did not call any physicians or other medical professionals to testify; however, he testified that he did not agree with the opinions of Dr. Fait, Dr. Weber, and Dr. Khanna. Respondent submitted medical records from his treating physicians to support his appeal.

After considering all of the evidence introduced, as well as arguments by the parties, the ALJ denied Respondent's appeal. The ALJ found that the only competent medical evidence showed that Respondent was not incapacitated from performing his job duties as a Correctional Counselor II based on orthopedic (left elbow, left shoulder, knees and feet), cardiac (chest pain and hypertension) and internal (diabetes and tingling fingers) conditions. The ALJ further noted that Respondent offered no competent medical opinions refuting the evidence presented by CalPERS. Thus, Respondent failed to meet his burden of proof, and his application must be denied.

The ALJ concluded that Respondent is not eligible for industrial disability retirement.

Pursuant to Government Code section 11517 (c)(2)(C), the Board is authorized to "make technical or other minor changes in the Proposed Decision." In order to avoid ambiguity, staff recommends that the Proposed Decision be modified as follows: (1) by replacing the word "a" with "an industrial" before the words "disability retirement" on page three, paragraph 2; page four, paragraph 3; page twenty-one, paragraph 1; page twenty-three, paragraph 10; page 26, paragraph 21; page twenty-seven, paragraph 22 and page twenty-eight, within the "Order;" (2) by inserting the word, "industrial" before the words, "disability retirement" on page two, within the "Issue" paragraph; page three, within the "Summary of Decision;" page four, paragraph 4; page twenty, paragraph 28 and page twenty-seven, paragraph 22 of the Proposed Decision; and (3) by replacing "correctional officer" with "Correctional Counselor II, Specialist" on page twenty, paragraph 28.

For all the above reasons, staff argues that the Proposed Decision be adopted, as modified, by the Board.

February 19, 2020

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Austa Wakily
Senior Attorney