

ATTACHMENT A
THE PROPOSED DECISION

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

In the Matter of the Application for Disability Retirement of:

LAURA A. WILLIAMS,

Respondent,

and

CALIFORNIA SCHOOL BOARDS ASSOCIATION,

Respondent.

Case No. 2015-0061

OAH No. 2015081030

PROPOSED DECISION

This matter was heard before Tiffany L. King, Administrative Law Judge, Office of Administrative Hearings, State of California, on August 25, and October 17, 2016, in Sacramento, California.

Rory J. Coffey, Senior Staff Counsel, represented petitioner California Public Employees' Retirement System (CalPERS).

Respondent Laura A. Williams (respondent) was present and represented herself.

There was no appearance by or on behalf of respondent California School Boards Association (CSBA), and the matter proceeded as a default against CSBA, pursuant to Government Code section 11520.

Evidence was received, the record was closed, and the matter was submitted for decision on October 17, 2016.

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CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM
FILED Nov. 28 2016
C. Bodily

ISSUE

On the basis of internal (diabetes and thyroid) conditions, is respondent permanently disabled or substantially incapacitated from performing her usual and customary duties as a Government Technology Specialist for CSBA?

PROCEDURAL FINDINGS

1. Respondent was employed by CSBA as a Government Technology Specialist. On or about January 9, 2014, respondent signed and filed an application for disability retirement on the basis of internal conditions (diabetes and thyroid). CalPERS received her application on January 17, 2014. By virtue of her employment, respondent is a state miscellaneous member of CalPERS subject to Government Code section 21150. She has the minimum service credit necessary to qualify for retirement.

2. After reviewing the application, CalPERS retained Sophie W. Cole, M.D., to conduct an independent medical examination (IME) of respondent's internal conditions and write a report. After reviewing Dr. Cole's initial IME report and first and second supplemental reports, CalPERS determined that respondent was not permanently and substantially incapacitated from the performance of her duties as a Government Technology Specialist.

3. By letter dated September 11, 2014, CalPERS notified respondent of its determination and advised her of her appeal rights. On October 1, 2014, respondent timely filed an appeal and request for hearing. On August 17, 2015, Anthony Suine, in his official capacity as Chief, Benefit Services Division, Board of Administration, CalPERS, made and filed the Statement of Issues.

4. The matter was set for evidentiary hearing before an Administrative Law Judge with the OAH on January 27, 2016. At the hearing, respondent brought a significant amount of new medical records which Dr. Cole had not previously reviewed. At CalPERS' request, the hearing was continued to May 12, 2016. Approximately a week prior to hearing, respondent again produced new medical records which Dr. Cole had not previously reviewed. The parties' joint motion to vacate the hearing was granted. Subsequently, the matter was again set for hearing on August 25, 2016.

5. The evidentiary hearing commenced on August 25, 2016. At the start of respondent's case in chief, she produced additional medical records which Dr. Cole had not previously reviewed. At CalPERS' request, the hearing was continued to allow Dr. Cole to review the additional records. The evidentiary hearing resumed and concluded on October 17, 2016.

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FACTUAL FINDINGS

Employment History and Duties of a Government Technology Specialist

6. Respondent was hired by CSBA in 1993 and worked there for 21 years. As a Government Technology Specialist, she gave presentations and traveled frequently. Her position description listed her essential duties and responsibilities, in relevant part, as follows:

- Performs a variety of administrative analytical and customer support activities; Organizes and implements administrative assignments and special projects;
- Researches, compiles, organizes, and analyzes information and data for special projects and various reports, publications, and newsletters; prepares, reviews and processes special analytical and technical reports, contracts, policies, and procedures relating to a core function of departmental operations; designs and implements forms, prepares written materials to explain CSBA programs and procedures;
- Creates content, develops and conducts presentations to boards and groups promoting CSBA technology, programs, services, and trainings;
- Represents CSBA at annual conferences and other events manning the governance technology booth;
- Addresses concerns, inquiries, or complaints from member agencies or the general public in a professional manner; researches information, identifies and reports findings, and takes appropriate action to ensure an expedient and satisfactory resolution;
- Develops, verifies, and reviews forms, contracts, and reports;
- Assists with researching, formatting and customizing content for program specific correspondence, forms, reports, presentations, marketing, and manuals.

In addition, respondent was required to have knowledge of both MAC and Android PC systems, the legislative process, languages and chapter review. Respondent stopped working on January 27, 2014.

Respondent's Application and Testimony

7. In her application for disability retirement, respondent described her specific disability as type 1 diabetes and neutropenia, first occurring in April 2012. Respondent was uncertain as to the cause of her disability, asserting it may be an autoimmune virus but noting her doctors remained inconclusive about the cause. Respondent noted her disability negatively impaired her vision and decision-making, and caused her to experience chronic fatigue. Regarding how the disability affects her ability to perform her job, respondent wrote she is "not able to concentrate or view computer for long periods, not able to travel, fatigue, trouble concentrating with blood sugar irregularity." At the time she filed the application, respondent was working part-time, noting that she had missed promotional opportunities due to her illness. Finally, respondent wrote:

This has been a very difficult time. As my blood sugar goes out of control ... I am unable to remember words or conduct trainings. It is very hard to focus which is needed to perform my job duties. My duties require a high level of organization, focus and the ability to verbally relay information to others. My vision has gotten worse and I cannot look at a computer screen longer than 40 minutes at a time.

8. Respondent testified she was first diagnosed with type 2 diabetes in 2002, which she controlled with oral medication. Her condition did not affect her performance at work. Beginning in 2012, however, she started feeling very tired all the time. She had blurry vision, needed to drink a lot of water, and frequently used the restroom. Her symptoms began to affect her job performance. She experienced incidents of slurred speech and an inability to articulate, causing her embarrassment when giving presentations to school districts. Tests revealed her blood sugar levels were extremely high. She was diagnosed with type 1 diabetes. She continued to experience fluctuation in her blood sugar levels, causing her to feel fine then worse again. In 2012, at her doctor's recommendation, she went out on disability leave. She returned to work in September 2012, but at a reduced schedule. Throughout 2013, stress from her work had a negative impact on her blood glucose levels. It was increasingly difficult for her to work long shifts. Toward the end of 2013 and in early 2014, respondent was feeling very sick. She lacked energy and had difficulty controlling her glucose levels with diet, exercise and insulin. She missed significant time at work and received her first negative performance evaluation. On January 27, 2014, at her employer's request, she resigned from her position.

9. Respondent continued to consult with numerous specialists to try to control her diabetes. Changes in insulin dosage, diet, and exercise were insufficient. She had difficulty absorbing insulin due to an allergy to an additive to the insulin. Her doctors switched her to an insulin pump in December 2015. However, respondent erupted in a rash wherever she tried to use the pump. Respondent continued to use the pump but changed her infusion site with a catheter, which allowed her to receive a steady flow of insulin throughout the day, but this did not help with desensitization. Respondent explained she still experiences fatigue, mood swings and confusion. She often experiences high blood glucose levels when she wakes up in the morning. It is hard for her to get up and perform simple tasks because she is so tired.

10. By the summer of 2016, respondent had a severe allergic reaction to all available preparations of insulin and all available treatments failed. Her physicians recommended she undergo pancreatic or islet cell transplant.

Medical Evidence

11. Respondent did not call any medical experts to testify at hearing, but she introduced medical records from multiple medical treatment providers, many of which are summarized in Dr. Cole's IME and supplemental IME reports. All of this evidence was received as administrative hearsay, and has been considered to the extent permitted under Government Code section 11513, subdivision (d).¹

12. In January 2014, respondent's family physician, Julie Baur, D.O., completed a CalPERS' form, Physician's Report on Disability. She reported respondent suffered from fatigue, poor concentration, weakness, and blurry vision as a result of her type 1 diabetes (primary) and thyroid disorder (secondary). Dr. Baur opined respondent was substantially incapacitated from performance of her usual job duties. Specifically, respondent was unable to perform analytical thinking, critical thinking and decision-making, and she could not travel or conduct presentations. Dr. Baur indicated that respondent's incapacity was very likely permanent, though she could not be certain, noting respondent's "blood glucose [had] been very erratic and difficult to control for the last few years." Dr. Baur completed a second Physician's Report on Disability on February 5, 2014, in which she confirmed her findings and opinions in the first report. In the second report, however, Dr. Baur opined without equivocation that respondent's incapacity was permanent.

¹ Government Code section 11513, subdivision (d), in relevant part, provides:

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.

13. On December 15, 2014, Shannon Krisa, Physician's Assistant (PA), completed a Functional Capacity Questionnaire, in which she listed respondent's diagnoses as "diabetes type 1 uncontrolled, peripheral neuropathy due to diabetes, headaches, hypertension, insomnia, thyroid disorder, [history] of neutropenia." PA Krisa described respondent's prognosis as poor. She opined that respondent was unable to tolerate even low stress jobs, noting that "stress can cause fluctuations in her glucose levels." PA Krisa continued that respondent could not stand for more than ten minutes at one time before needing to sit down or walk around, and could not stand or walk more than two hours in an eight-hour work day. Respondent's condition restricted her ability to twist, stoop (bend), crouch, and climb stairs or ladders. She also had significant limitations in doing repetitive reaching, handling or fingering. PA Krisa concluded:

[Respondent] is unable to perform at any job with reasonable continuity due to unpredictable and rapid fluctuations in glucose. This causes significant anxiety in regards to when and where glucose levels will fluctuate. In addition, she worries about embarrassment associated with her crying, irritability, and cognitive decline during hypoglycemic events.

14. IME by Dr. Cole: CalPERS retained Dr. Cole to conduct an IME of respondent. Dr. Cole is board-certified in internal medicine. She was a staff physician at Kaiser Permanente Hospital in South San Francisco for 21 years. She has volunteered as a staff physician and clinical preceptor at Good Samaritan House Free Clinic since 2007. She also serves as a medical consultant for Phaedrus Internet Development, Inc.

15. On April 10, 2014, Dr. Cole evaluated respondent, which included soliciting respondent's medical and work history, reviewing her job description and relevant medical records, and a physical examination. Dr. Cole prepared a report to CalPERS dated April 10, 2014, and testified at hearing.

16. Respondent reported to Dr. Cole a two-year history of fatigue due to poorly controlled diabetes mellitus which was first diagnosed in 2001. In April 2012, she underwent a total abdominal hysterectomy and bilateral oophorectomy. After recovering from her surgeries, she returned to work part-time in October 2012. Respondent noted her symptoms of fatigue and decreased concentration had worsened over the past two years. Her blood sugar readings fluctuated from very high to very low. She wore a glucose monitoring device to help her adjust her insulin intake and maintained a strict diabetic diet. When her blood sugars were high, she experienced blurry vision and increased irritability.

Respondent was unable to meet her work deadlines or keep up at work. She experienced chronic headaches, back pain, and tingling and numbness in her feet. She regularly exercised by walking for one hour, two or three days a week. She could sit for longer than one hour without difficulty. She had no difficulty walking or climbing, and could perform other activities of daily living such as vacuuming, carrying groceries, washing

a car, and making a bed. Respondent stated she stopped working on January 27, 2014 due to symptoms of fatigue, blurry vision, and difficulty in meeting her tasks at work.

17. At the time of the IME, respondent had the following prescriptions: Lantus NPH; Humalog insulin; Lotensin (for high blood pressure); Estrace (post menopause); testosterone topical cream (for vaginal dryness); hydrochlorothiazide (for blood pressure and fluid retention; morphine (for chronic headaches); and Norco. Although prescribed, respondent was no longer taking Norco.

18. Dr. Cole then conducted a physical examination of respondent. Respondent's vital signs were normal. Upon neurologic examination, respondent's cognitive abilities, recall and memory were normal. Cranial nerves were grossly intact with no sensory or motor deficit. Respondent had a normal gait when walking. Her mental status was normal.

19. Dr. Cole's review of respondent's medical records from May 2012 to April 2014 included the following:

a. Michael Laidlaw, M.D., an endocrinologist, evaluated respondent for diabetes mellitus and subclinical hyperthyroidism beginning in May 2012. In March 2013, Dr. Laidlaw referred respondent for a gastric emptying study due to abdominal pain possibly caused by gastroparesis. The study was normal. In April 2013, respondent complained of night snoring, daytime fatigue, and weight gain. In June 2013, Dr. Laidlaw referred respondent to a gastrointestinal specialist for chronic nausea. He noted respondent's diabetes was not well controlled. In September 2013, Dr. Laidlaw put respondent on a strict diet and directed her to continue her insulin regimen. In April 2014, respondent wore a glucose monitor which showed her blood glucose levels ranging from 44 to 247. Most episodes are between 131 and 280.

b. Diagnostic studies showed respondent's hemoglobin A1C and glucose levels were as follows:

6/22/2012 – A1C of 7.6; glucose level of 162
9/6/2012 – A1C of 8.2; glucose level of 161
1/14/2013 – A1C of 9.1; glucose level of 214
6/26/2013 – A1C of 8.1; glucose level of 296
12/9/2013 – A1C of 9.3; glucose level of 178

c. Laboratory studies showed respondent had elevated blood glucose but no diabetic ketoacidosis, based on normal serum bicarbonate levels. She had no evidence of clinical hyperthyroidism or hypothyroidism, and no evidence of metabolic derangement, with normal electrolytes and normal serum calcium levels.

20. Dr. Cole diagnosed respondent with: (1) diabetes mellitus, poorly controlled; (2) diabetic peripheral neuropathy, mild; (3) subclinical hyperthyroidism, clinically euthyroid; (4) surgical menopause due to bilateral oophorectomy; (5) chronic headaches; and (6) morphine dependency. She further noted:

Evaluation and review of the medical records does not reveal any significant medical or physical incapacity. [Respondent's] blood sugars are not well controlled on her current regimen; however, she has no overt clinical deterioration from this, no evidence of chronic infection, no evidence of metabolic ketoacidosis, and no evidence of electrolyte abnormalities. It is my impression that her chronic morphine use is also contributing to her fatigue and lethargy. It remains unclear after review of the records as to why she needs to be on chronic opiate use. My evaluation did not reveal complaints of headaches, back pain, or physical impairment to justify daily morphine use.

Further, [respondent's] thyroid condition is considered stable, and recent thyroid studies were consistent with clinical euthyroidism, with no evidence of overt thyroid disease. In addition, recent removal of both of her ovaries has precipitated surgical menopause, which is likely contributing to her symptoms of fatigue, irritability, headaches, sleep disturbance, and poor concentration.

21. Dr. Cole opined that, at the time of the IME, there were no job duties respondent was unable to perform due to a physical or mental condition. She further opined respondent was not substantially incapacitated for performance of her usual duties as she was able to perform her activities of daily living, walking for one hour two to three times a week, driving, cooking, and grocery shopping. Respondent's neurological examination did not reveal any deficits or cognitive impairment. Her thought process and judgments were within normal limits.

22. First Supplemental Report: Dr. Cole prepared a supplemental report dated July 21, 2014, following her review of additional medical records.

23. During this time period, respondent was treated by Stephen Wilmarth, M.D., and Alexander Grand, M.D., from the Kaiser Permanente Eye Clinic, for a diabetic eye examination and excessive tearing. At all times, her vision was 20/20 in both eyes. On February 28, 2014, respondent was diagnosed with epiphora of both eyes. The draining system obstruction was removed, punctal dilation was performed, and balanced salt solution was injected to the canalicular and nasolacrimal duct system to allow eventual drainage to the system. The same procedure was performed on both eyes of the lower canalicular and nasolacrimal systems and a snip punctoplasty was performed in both eyes. On April 25, 2014,

respondent was seen for follow up. She continued to have tearing in both eyes, but declined further intervention at that time.

24. Dr. Cole updated her diagnosis of respondent as follows: (1) bilateral epiphora status post punctoplasty with good results, visual acuity 20/20 and stable; (2) diabetes mellitus, fully controlled; (2) diabetic peripheral neuropathy, mild; (3) subclinical hyperthyroidism, clinically euthyroid; (4) surgical menopause due to bilateral oophorectomy; (5) chronic headaches; and (6) morphine dependence. Dr. Cole further noted that her "evaluation and review of medical records [did] not reveal any significant medical or physical incapacity. The additional medical records did not change Dr. Cole's opinion that respondent was not substantially incapacitated for the performance of her usual duties.

25. Second Supplemental Report: Dr. Cole prepared a second supplemental report dated August 7, 2014, following her review of further medical records.

26. On February 25, 2014, respondent was evaluated by PA Krisa for symptoms of vaginitis and sinusitis. She was treated with antibiotics and antifungal therapy. Respondent was again evaluated by PA Krisa on June 10, 2014, for a possible yeast vaginitis and plans to wean off morphine. She was treated with an antifungal therapy and Tylenol with Codeine. On June 26, 2014, PA Krisa evaluated respondent for preoperative evaluation for abdominoplasty. Though at an increased risk for surgery due to her diabetes, respondent was cleared for surgery.

27. Dr. Cole provided the following updated diagnosis: (1) diabetes mellitus, fully controlled; (2) recurrent vaginitis, responded to treatment; and, (3) mild diabetes peripheral neuropathy. Dr. Cole maintained her opinion that respondent was not substantially incapacitated for the performance of her usual duties. Dr. Cole further noted:

Review of additional medical records, once again, revealed poorly controlled diabetes. However, despite two episodes of vaginitis which responded to treatment, there is no evidence of substantial medical incapacity in this patient. Her vital signs remain normal. She has no evidence of sepsis or persistent abscess. [Respondent] has no evidence of significant metabolic derangement with the exception of her elevated blood glucose. She has no evidence of ketoacidosis or diabetic ketoacidosis, and she has no evidence of poor sequelae from her diabetes at this time.

28. Dr. Cole noted that her opinion that respondent was not substantially incapacitated from the performance of her usual job duties remained unchanged.

29. Third Supplemental Report: Dr. Cole prepared a third supplemental report dated May 31, 2016, following her review of additional medical records from UC Davis Health System provided by respondent. Dr. Cole summarized these records, in relevant part, as follows:

a. In December 2014 and January 2015, Sonal Phatak, M.D., evaluated respondent for diabetic control and digestive issues. Her insulin dosage was adjusted and a gastric emptying study was requested. On March 25, 2015, Dr. Phatak evaluated respondent for gastroparesis. Respondent complained of food not digesting, occasional gastroesophageal reflux disease (GERD), gradual weight loss, blood in her rectum, bloating, and constipation. She was referred for a gastric emptying scan and advised to change her diet.

b. On April 2, 2015, an upper endoscopy showed respondent had esophagitis and gastritis. Biopsies were obtained. Respondent was treated with a proton pump inhibitor with 20 milligrams of Omeprazole daily. On April 28, 2015, a solid gastric retention scintigraphy showed borderline increased solid gastric retention of 62.6 percent at 2 hours, and normal solid gastric retention of 5.89 percent at 4 hours.

c. In October 2015, respondent was evaluated by Ricardo Maselli, M.D., a neurologist, for hyperesthesia in the thighs. Nerve conduction studies showed "abnormal study: mononeuropathy of bilateral femoral cutaneous nerves, more severe on the left side, mononeuropathy of the right medial plantar nerve." There was no evidence of proximal myopathy or generalized neuropathy to explain symptoms of weakness.

d. In November 2015, respondent was evaluated for fatigue, lightheadedness, and a skin rash at her insulin injection site. It was recommended she switch to an insulin pump to avoid local reaction. On November 19, 2015, an electromyogram showed bilateral femoro-cutaneous neuropathy (meralgia paresthetica). It also revealed right medial plantar nerve dysfunction, but no generalized diffuse nerve damage or muscle disease. Dr. Phatak recommended weight loss and avoiding tight garments around the waist.

e. On December 2, 2015, an esophagram showed esophageal dysmotility at the middle third of respondent's esophagus.

f. On January 25, 2016, Dr. Phatak conducted a follow up evaluation for diabetes and pump infusion assessment. Respondent's blood glucose levels had improved, she had more energy, and believed her diabetes is better on the pump.

30. In addition to the diagnoses listed in her initial and two supplemental reports, Dr. Cole added the following diagnoses to respondent's condition: (1) hypersensitivity reactions to insulin-due to insulin site irritation; (2) esophagitis/gastritis; (3) borderline gastric retention; (4) esophageal dysmotility at the middle third of the esophagus; and (5) meralgia paresthetica (bilateral femoro-cutaneous neuropathy). Dr. Cole further noted:

Since my IME evaluation in 2014 until January in 2016, [respondent] did have problems with localized skin reactions from insulin injection site. Several types of hypersensitivity reactions to insulin preparations have been described. These reactions may be caused by the insulin itself or by additives within the preparation. The records in this case support the conclusion that [respondent's] hypersensitivity skin reactions to her insulin injections is likely due to the insulin preparations, and localized insulin site irritation. ... [H]er symptoms and skin rash have resolved since her therapy was switched to insulin pump for gradual continuous infusions, instead of injections. There is no evidence ... that [respondent] has a true allergy to the "insulin" medication itself. Since switching to insulin pump infusion, her diabetic control has improved, and [respondent] has noted improved energy and well-being

Regarding respondent's gastrointestinal symptoms, Dr. Cole noted that respondent responded to medicinal treatment. She maintained her nutritional status and weight, and showed no signs of clinical incapacitation. With respect to symptoms of paresthesia, Dr. Cole opined there was no evidence of diffuse neuropathy, and that nerve damage is a frequent complication of diabetes mellitus. Respondent's nerve damage was mild and limited to superficial/cutaneous nerves. Respondent did not exhibit muscle loss or overt sensory loss. Her neurological examination did not show signs of physical incapacitation.

31. Dr. Cole further opined:

After review of [respondent's] job description and the additional medical records provided, I have concluded that *[respondent] is now not able to withstand prolonged sitting or standing for longer than [one] hour intervals without changes in position, due to her paresthesia in her toes (decreased sensation)*. Her nerve conduction study did confirm bilateral cutaneous femoral neuropathy, which would account for her weakness. She would therefore be at risk of gait disturbance or falls with prolonged standing more than one hour, and prolonged sitting for more than one hour would likely cause her to have more sensory loss and pain in her feet. *Specifically, she is unable to conduct prolonged continuous computer and keyboarding work, or presentations that would require her to sit or stand for longer than one hour at a time, without changing position.*
(Emphasis added.)

Notwithstanding the above, Dr. Cole maintained that respondent was not substantially incapacitated from performance of her usual duties, as evidenced by her ability to perform daily living activities of walking, driving, cooking, grocery shopping, and thoughtful

planning. Subsequent neurological evaluation since Dr. Cole's 2014 IME confirmed normal neurologic examination with no deficits of cognitive impairment. Dr. Cole further noted respondent's diabetic control was "much improved since switching her therapy to insulin infusion pump."

32. Fourth Supplemental Report: Dr. Cole prepared a fourth supplemental report, dated June 30, 2016, following her review of additional medical records. Dr. Cole summarized these records, in relevant part, as follows:

- a. On July 11, 2014, Alan Lim, M.D., performed abdominoplasty for abdominal pannus. Respondent tolerated the procedure without complications.
- b. On December 14, 2014, an abdominal ultrasound was performed, showing small intraabdominal seromas, but otherwise normal.
- c. On March 11, 2015, laboratory studies showed respondent's hemoglobin A1C at 9.2, and average glucose of 217.
- d. On April 8, 2015, PA Krisa evaluated respondent for diabetes. Respondent was still having difficulty controlling glucose, and still having some tingling and numbness in toes. An esophagogastroduodenoscopy (EGD) study showed gastritis. Respondent started on Prilosec. A gastric emptying study was scheduled.
- e. On June 22, 2015, Dr. Phatak evaluated respondent for diabetes insulin dosage adjusted. Respondent complained of fatigue, intermittent lightheadedness, weight loss, and hair loss. Thyroid function studies and ACTH stimulation test were all normal. Dr. Phatak also noted an erythematous rash to various types of long-acting and short-acting insulins. Respondent complained of burning with Levemir and Novologue – this was thought due to "meralgia paresthetica versus polyneuropathy."
- f. On July 21, 2015, Richard Douglas, D.P.M.² evaluated respondent for an ingrown nail of the right great toenail. She was treated with topical antibiotics.
- g. On December 15, 2015, PA Krisa evaluated respondent for hoarseness for one month. Respondent's diabetes remains poorly controlled despite closely working with UC Davis diabetes program. She was on insulin pump. Her blood sugars were over 700 for 24 hours. Respondent also complained of a "foreign body sensation." An esophagram showed possible gastroparesis. She was also diagnosed with peripheral neuropathy. She had completely weaned off her long acting morphine, and is using Norco as needed and Xanax as needed. She was referred for ENT evaluation.

² Doctor of Podiatric Medicine.

33. Dr. Cole noted that the additional medical records did not change her comments and conclusions regarding respondent's diagnoses and substantial incapacity. Dr. Cole further noted:

[Following diagnosis of mononeuropathy] – Therefore, since 6/22/2015, [respondent] has been unable to conduct prolonged continuous computer and keyboarding work or presentation that would require her to sit or stand longer than one hour at a time without changing position.

[¶] ... [¶]

[Respondent's] neurologic examination did not find evidence of sensory loss or weakness. However, in patients with diabetes mellitus, this is a progressive, deteriorating condition of nerve damage and loss of function. It is quite common to have a normal examination, in the setting of subjective symptoms of nerve damage, as is the case with [respondent].

Her present subjective symptoms of sensory loss would likely progress over time, and it would then also become evident on physical exam. The point is, her symptoms are real, they have been confirmed by the nerve conduction study, and they would likely progress over time.

For now, restrictions of limiting her standing or sitting for no longer than one hour at time is appropriate.

34. Fifth Supplemental Report: Dr. Cole prepared a fifth supplemental report, dated September 27, 2016, following her review of additional medical records. Dr. Cole summarized these records, in relevant part, as follows:

a. On May 27, 2016, Lily A. Chaput, M.D., evaluated respondent for chronic continuous use of opioids and uncontrolled diabetes mellitus type-1. Respondent complained of feeling fatigued all the time, had significantly curtailed her daily activities and minimized carbohydrate intake.

b. On July 1, 2016, Dr. Phatak noted that respondent has had very poor diabetes control despite strict compliance with insulin treatment, her current hemoglobin A1C = 9.2, and she has recently developed retinopathy in the past year due to poor glucose control. She was noted to have erythematous rash on her skin where she uses insulin pump. Dr. Phatak's plan was to continue current insulin pump basal rates, external referral for transplant surgery, evaluate for possible islet cell transplantation, as respondent cannot tolerate multiple insulin formulations without significant hypersensitivity reactions, and as allergy/immunology specialists have been unable to adequately treat her insulin

hypersensitivity reactions. For these reasons, she believed respondent may benefit from evaluation for islet cell transplant or other modality.

c. In her July 15, 2016 follow up note, Dr. Phatak reported that respondent “has had very poor diabetes control despite strict compliance with insulin treatment ... we feel that [respondent] would benefit from evaluation for islet cell transplant or other modality.”

d. On August 25, 2016, laboratory studies showed respondent’s hemoglobin A1C at 10.1, and average glucose of 243.

e. By letter dated September 1, 2016, respondent’s appointment for pancreas transplant was confirmed for Wednesday, November 2, 2016.

35. After reviewing the additional medical records, Dr. Cole added the following diagnoses to respondent’s condition: (1) hypersensitivity reactions to multiple formulations of insulin; (2) inconsistent and decreased insulin absorption; (3) diabetic retinopathy; (4) poorly controlled type 1 diabetes mellitus; and (5) referral for pancreas transplant. Dr. Cole further noted:

These medical records demonstrate that [respondent] now has incapacitating clinical problems with exogenous insulin therapy, failure of insulin-based management to prevent complications, such as retinopathy and neuropathy. Since she has type-1 diabetes mellitus, her own pancreas does not make insulin. [Respondent] now requires pancreatic transplantation. In the absence of insulin, she will die from complications of uncontrolled diabetes mellitus. Infusion of insulin via the usual mechanisms of injections and pumps have failed, due to her intractable allergy to multiple exogenous insulin preparations. The option of a pancreas or “islet cells” transplantation (usually placed in the pelvis), will result in these new cells producing insulin and secrete the insulin directly into her systemic circulation (main blood stream), thereby bypassing the issue of allergic reactions to exogenous insulin preparations. The goals of transplantation are to restore glucose-regulated endogenous insulin secretion (made inside the body), arrest the progression of the complications of diabetes, and improve quality of life.

Given the complexity of her [t]ype-1 diabetes mellitus, with inconsistent and decreased exogenous insulin absorption, causing unpredictable swings in her blood glucose, having failed the usual medical therapy and now require pancreas transplant, the fluctuations in her blood glucose, her chronic fatigue, lightheadedness, neurovascular complications (evidenced by

retinopathy and neuropathy), *it is my medical opinion that [respondent] is substantially incapacitated from performance of her duties, effective on July 1, 2016, the date she was referred for transplant.* (Emphasis added.)

36. Dr. Cole explained respondent is unable to perform specific job duties as follows:

I have concluded that [respondent] is unable to perform her duties of: reviewing legislation and giving presentations, technical analytical assessments and providing organizational support. The frequent and labile swings in her blood sugar will cause her to feel fatigued, dizziness, blurry vision, headaches, inability to focus and concentrate on tasks, inability to read and summarize legislative processes, writing or giving presentations. In addition, sudden, unpredictable fluctuations in her blood glucose also causes lapse in memory and recall, due to the fact that very high or low blood glucose adversely affect brain cell function. This metabolic abnormality causes slowing of her mental function, and she is unable to execute mental tasks, such as processing and organizing legislative information. Further, she cannot stand for long periods of time due to neuropathy in her leg causing numbness and weakness, also due to fatigue and lightheadedness.

The unpredictable nature of the swings in her blood glucose poses an on-going medical threat to her well-being. Her inability to adequately treat these frequent swings in her blood glucose levels places her at risk for sudden loss of consciousness, falls and significant metabolic abnormalities, which may often require hospitalization.

37. Dr. Cole opined respondent became substantially incapacitated, effective July 1, 2016, noting:

It is my medical opinion that [respondent] is presently substantially incapacitated from performance of her duties, effective July 1, 2016, when she was referred for pancreatic transplantation. Until she receives a new pancreas, she is medically incapacitated, as she has no appropriate interim treatment options. She is presently medically unstable to perform her duties due to persistent labile, uncontrolled diabetes with marked fluctuations in blood sugar, causing persistent lightheadedness, weakness, episodic metabolic abnormalities

(ketosis), and essentially medically unstable. This medical instability causes her both mental and physical incapacity.

Regarding duration, Dr. Cole noted:

Assuming she has a successful pancreas transplantation, it [is] quite possible that her incapacitation could be temporary. However, the perioperative period can be complicated by complications of immunosuppression, graft loss, rejection and many other metabolic derangements. The expected duration of her incapacitation could last up to five-years.

38. By letter dated October 17, 2016, CalPERS notified respondent of Dr. Cole's findings and its continued denial of her disability retirement application because respondent was not found to be disabled from the date she last worked to present.

Discussion

39. To meet her burden, respondent was required to produce a competent medical opinion to establish her substantial incapacity. (Gov. Code, § 21156, subd. (a)(2).) She offered no expert medical testimony at hearing, but submitted reports from Dr. Baur and PA Krisa which deemed her to be permanently and substantially incapacitated from the performance of her duties due to her type 1 diabetes as of January 2014. However, these reports were made on preprinted forms and did not include an underlying report or otherwise sufficient explanation supporting their findings of substantial incapacity. (See, *People v. Bassett* (1968) 69 Cal.2d 122, 144 [the value of an expert witness's opinion lies with his explanation of the factual predicate for his opinion]; *People v. Williams* (1962) 200 Cal.App.2d 838, 845 ["[T]he opinion of an expert is no better than the reasons upon which it is based"].) For the same reasons, the conclusions of Dr. Baur and PA Krista that respondent was permanently and substantially incapacitated as of January 2014 were insufficient for purposes of qualifying for disability retirement.

40. By contrast, Dr. Cole applied the standards applicable in disability retirement proceedings to reach her opinion that respondent was not permanently substantially incapacitated from performing the usual duties of an Government Technology Specialist at the time she filed for disability retirement in January 2014. Respondent contends that, in concluding that respondent's substantial incapacity began on July 1, 2016, Dr. Cole failed to consider the many months she suffered from uncontrolled diabetes as she tried and failed all available treatments before being referred for pancreas transplant. Respondent's argument is understandable. However, she offered no competent medical evidence, other than the reports previously discussed, to establish an earlier date for her substantial incapacity. Thus, Dr. Cole's finding that respondent's substantial incapacity began on July 1, 2016, is uncontroverted.

41. In sum, when all the evidence is considered, respondent failed to establish that, at the time she applied for disability retirement, she was substantially and permanently incapacitated from performing the usual duties of a Government Technology Specialist. Consequently, her disability retirement application must be denied.

LEGAL CONCLUSIONS

1. Respondent has the burden of proving she is eligible for disability retirement benefits by a preponderance of the evidence. (*McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051-1052, fn. 5.) Evidence that is deemed to preponderate must amount to "substantial evidence." (*Weiser v. Board of Retirement* (1984) 152 Cal.App.3d 775, 783.) To be "substantial," evidence must be reasonable in nature, credible, and of solid value. (*In re Teed's Estate* (1952) 112 Cal.App.2d 638, 644.)

2. To meet her burden, respondent had to prove that, at the time she applied, she was "incapacitated physically or mentally for the performance of [her] duties in the state service." (Gov. Code, § 21156.) As defined in Government Code section 20026,

"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.

3. An application for disability retirement of a member may be made by the member's employer, the governing body of the contracting agency with whom a member is employed, or the member herself. (Gov. Code, § 21152, subs. (a), (c), and (d).) The application must be made while the member is still in state service or within four months after the discontinuance of her state service. Upon receiving the application, the Board shall order a medical evaluation of the member to determine if she is incapacitated for the performance of duty. (Gov. Code, § 21154.) If the medical examination and other available information show, to the satisfaction of the Board, that the member is physically or mentally incapacitated for the performance of her duties and is eligible to retire for disability, the Board shall immediately retire her for disability. (Gov. Code, § 21156, subd. (a)(1).)

4. The courts have interpreted the phrase "incapacitated for the performance of duty" to mean "the substantial inability of the applicant to perform [her] usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 877.) Discomfort, which may make it difficult to perform one's duties, is insufficient to establish permanent incapacity for the performance of her position. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207; citing, *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, 862.)


5. As set forth in Factual Findings 39 through 41, respondent did not meet her burden. There was insufficient evidence based upon competent medical opinion that respondent was permanently and substantially incapacitated from performing the usual duties of Government Technology Specialist at the time she filed for disability retirement in January 2014. Consequently, her disability retirement application must be denied.

ORDER

The application of Laura A. Williams for disability retirement is DENIED.

DATED: November 22, 2016

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Tiffany L. King
Administrative Law Judge
Office of Administrative Hearings