AGENDA

A REGULAR MEETING OF THE BOARD OF RETIREMENT

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA

9:00 A.M., WEDNESDAY, NOVEMBER 4, 2015

I. CALL TO ORDER

II. PLEDGE OF ALLEGIANCE

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of October 7, 2015

B. Approval of the Minutes of the Regular Meeting of October 15, 2015

IV. REPORT ON CLOSED SESSION ITEMS

V. OTHER COMMUNICATIONS

A. For Information

1. September 2015 All Stars

2. Chief Executive Officer's Report (Memo dated October 27, 2015)

VI. PUBLIC COMMENT

VII. CONSENT AGENDA

A. Ratification of Service Retirement and Survivor Benefit Application Approvals.

B. Requests for an administrative hearing before a referee. (Memo dated October 23, 2015)

VII. CONSENT AGENDA (Continued)

C. Recommendation as submitted by Ricki Contreras, Division Manager, Disability Retirement Services: That the Board dismiss with prejudice the appeal for an earlier effective date in the case of **Eric L. Buege.** (Memo dated October 22, 2015)

D. Recommendation as submitted by Ricki Contreras, Division Manager, Disability Retirement Services: That the Board dismiss with prejudice the appeal for a service-connected disability retirement in the case of **Roberto C. Suria Vazquez.** (Memo dated October 22, 2015)

E. Recommendation as submitted by Vivian H. Gray, Chair, Disability Procedures & Services Committee: That the Board approve Kenneth P. Scheffels, M.D. – Board Certified Orthopedist and Thomas W. Fell, Jr., M.D. – Board Certified Orthopedist to the LACERA Panel of Physicians for the purpose of examining disability retirement applicants. (Memo dated October 13, 2015)

F. Recommendation as submitted by Gregg Rademacher, Chief Executive Officer: That the Board approve attendance of Board members at the 13th Annual Made in America: 2016 Taft-Hartley Benefits Summit on January 24-26, 2016 in Las Vegas, Nevada and approve reimbursement of all travel costs incurred in accordance with LACERA's Education and Travel Policy. (Memo dated October 19, 2015)

G. For information only as submitted by Ricki Contreras, Division Manager, Disability Retirement Services regarding the Application Processing Time Snapshot Reports. (Memo dated October 16, 2015)

VIII. NON-CONSENT AGENDA

A. Recommendation as submitted by Vivian H. Gray, Chair, Disability Procedures and Services Committee: That the Board approve the proposed updated "Policy Statement: Hiring of Panel Physicians: Qualifications, Licensing, Certification and Insurance Requirements for Board Appointed Panel Physicians." (Memo dated October 22, 2015)

VIII. NON-CONSENT AGENDA (Continued)

B. Recommendation as submitted by Les Robbins, Chair, Insurance, Benefits and Legislative Committee: That the Board direct its voting delegate to support inclusion of the following in the SACRS 2016 legislative platform:

1) District Status for 1937 Act County Employees Retirement Systems (SACRS #1) – To provide retirement systems the option to adopt district status.

2) Optional Employee Sworn Statements (San Diego #1) – To allow the retirement system to collect the member's enrollment information directly from the employer in lieu of a sworn statement from the member.

(Memo dated October 22, 2015)

C. Recommendation as submitted by Les Robbins, Chair, Insurance, Benefits and Legislative Committee: That the Board direct staff to work with LACERA's legislative advocate and seek an author to introduce legislation to amend the definition of Plan D in the Prospective Plan Transfer provisions of the County Employees Retirement Law of 1937. (Memo dated October 22, 2015)

D. Recommendation as submitted by Gregg Rademacher, Chief Executive Officer: That the Board delegate authority to the Chief Executive Officer to set the Chief Investment Officer's initial salary in the fourth quartile of the salary range.
(Memo dated October 23, 2015)

E. For information only as submitted by Barry W. Lew, Legislative Affairs Officer, regarding the 2015 Enacted Retirement Legislation. (Memo dated October 23, 2015)

F. For information only as submitted by Steven P. Rice, Chief Counsel, regarding the update on new proposed Reed DeMaio initiatives. (Memo dated October 27, 2015)

IX. GOOD OF THE ORDER
(For information purposes only)

X. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

XI. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability

B. Referee Reports

C. Staff Recommendations

1. Recommendation as submitted by Ricki Contreras, Manager, Disability Retirement Services Division: That the Board reject the application of **Olivia L. Padilla** for processing. (Memo dated October 19, 2015)

2. Recommendation as submitted by Allison E. Barrett, Senior Staff Counsel, Disability Litigation: That the Board find that the service-connected disability retirement application of **Anthony Riley** be deemed filed on the day after the last day of regular compensation in accordance with Government Code Section 31724. (Letter dated October 27, 2015)

3. For information only as submitted by Ricki Contreras, Manager, Disability Retirement Services Division, regarding the 2015 Quarterly Reports of Paid Invoices.
(Memo dated October 16, 2015)

XII. EXECUTIVE SESSION

A. Conference with Legal Counsel - Existing Litigation
(Pursuant to Paragraph (1) of Subdivision (d) of California Government Code Section 54956.9)

1. Ralph T. Nishihira v. Board of Retirement
2. George A. Vanecek v. Board of Retirement

XII. EXECUTIVE SESSION (Continued)

B. Conference with Legal Counsel – Pending Litigation
(Pursuant to Paragraph (1) of Subdivision (d) of California Government Code Section 54956.9)

1. Monique Hudson v. County of Los Angeles et. al.
Los Angeles Superior Court Case No. BC 458667

C. Conference with Legal Counsel - Anticipated Litigation
Significant Exposure to Litigation
(Pursuant to Paragraph (2) of Subdivision (d) of California Government Code Section 54956.9)

1. Administrative Appeal of Phillip Solano
2. Employment Claim of David Kushner

XIII. ADJOURNMENT

Documents subject to public disclosure that relate to an agenda item for an open session of the Board of Retirement that are distributed to members of the Board of Retirement less than 72 hours prior to the meeting will be available for public inspection at the time they are distributed to a majority of the Board of Retirement Members at LACERA's offices at 300 N. Lake Avenue, Suite 820, Pasadena, CA 91101, during normal business hours of 9:00 a.m. to 5:00 p.m. Monday through Friday.

Persons requiring an alternative format of this agenda pursuant to Section 202 of the Americans with Disabilities Act of 1990 may request one by calling Cynthia Guider at (626) 564-6000, from 8:30 a.m. to 5:00 p.m. Monday through Friday, but no later than 48 hours prior to the time the meeting is to commence. Assistive Listening Devices are available upon request. American Sign Language (ASL) Interpreters are available with at least three (3) business days notice before the meeting date.

MINUTES OF THE REGULAR MEETING OF THE BOARD OF RETIREMENT

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA

9:00 A.M., WEDNESDAY, OCTOBER 7, 2015

PRESENT: Shawn R. Kehoe, Chair

Alan Bernstein, Vice Chair

William de la Garza, Secretary

Anthony Bravo

Yves Chery

Vivian H. Gray

David L. Muir (Alternate Retired)

Ronald A. Okum (Arrived at 9:01 a.m.)

William Pryor (Alternate Member) (Arrived at 9:19 a.m.)

Les Robbins

ABSENT: Joseph Kelly

STAFF ADVISORS AND PARTICIPANTS

Gregg Rademacher, Chief Executive Officer

JJ Popowich, Assistant Executive Officer

Dr. Vito Campese, Medical Advisor

Steven Rice, Chief Counsel

Ricki Contreras, Division Manager
Disability Retirement Services

STAFF ADVISORS AND PARTICIPANTS (Continued)

Tamara Caldwell, Specialist Supervisor
Disability Retirement Services

Francis J. Boyd, Senior Staff Counsel
Legal Division

Steven Tallant, Senior Staff Counsel
Disability Litigation

Allison E. Barrett, Senior Staff Counsel
Disability Litigation

Eugenia W. Der, Senior Staff Counsel

Thomas J. Wicke, Attorney at Law
Lewis, Marenstein, Wicke & Sherwin, LLP

Michael Treger, Attorney at Law

I. CALL TO ORDER

The meeting was called to order by Chair Kehoe at 9:00 a.m., in the Board Room of Gateway Plaza.

II. PLEDGE OF ALLEGIANCE

Ms. Gray led the Board Members and staff in reciting the Pledge of Allegiance.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of September 2, 2015

Mr. de la Garza made a motion, Mr. Chery seconded, to approve the minutes of the regular meeting of September 2, 2015. The motion passed unanimously.

IV. REPORT ON CLOSED SESSION ITEMS

(Mr. Okum arrived at 9:01 a.m.)

There was nothing to report.

V. PUBLIC COMMENT

There were no requests from the public to speak.

VI. CONSENT AGENDA

Mr. de la Garza made a motion, Mr. Chery seconded, to approve the following agenda items. The motion passed unanimously.

A. Ratification of Service Retirement and Survivor Benefit Application Approvals.

B. Requests for an administrative hearing before a referee. (Memo dated September 24, 2015)

C. Recommendation as submitted by Ricki Contreras, Division Manager, Disability Retirement Services: That the Board dismiss with prejudice the appeal for service-connected disability retirement in the case of **Arnecy L. Hall.** (Memo dated September 17, 2015)

D. Recommendation as submitted by Vivian H. Gray, Chair, Disability Procedures & Services Committee: That the Board approve Roger Sohn, M.D. – Board Certified Orthopedist to the LACERA Panel of Physicians for the purpose of examining disability retirement applicants. (Memo dated September 17, 2015)

E. For information only as submitted by Ricki Contreras, Division Manager, Disability Retirement Services regarding the Application Processing Time Snapshot Reports. (Memo dated September 22, 2015)

VII. GOOD OF THE ORDER
(For information purposes only)

There was nothing to report during Good of the Order.

VIII. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Law Enforcement
Service-Connected Disability Applications

On a motion by Chair Kehoe, seconded by Mr. Bernstein, the Board of Retirement approved a service-connected disability retirement for the following named employees who were found to be disabled for the performance of their duties and have met the burden of proof:

APPLICATION NO.	NAME
382C*	GLEN T. WILLIAMS
383C	CECILIA A. GENTNER
384C	DUANE J. SCOTT
385C	CHRISTINE L. CARNS
386C	BRANDON D. LOVE
387C	ROBERT L. RUSH
388C	ANTHONY J. ARNOLD
389C**	JASON L. STULTING
391C	DAVEY S. CHAPMAN, JR.
392C**	PHILIP C. BARTH
393C	KERRY L. LEVENSON

* Granted SCD - Retroactive
** Granted SCD – Employer Cannot Accommodate

VIII. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Law Enforcement (Continued)
Service-Connected Disability Applications

APPLICATION NO.	NAME
394C	LANCE E. TRAVIS
395C	MARIO R. CUEVAS
396C*	ERIC K. HAMILTON

Safety-Fire, Lifeguard
Service-Connected Disability Applications

On a motion by Mr. Bernstein, seconded by Mr. Okum, the Board of Retirement approved a service-connected disability retirement for the following named employees who were found to be disabled for the performance of their duties and have met the burden of proof:

APPLICATION NO.	NAME
1704A	CLIFFORD R. MERIDTH
1705A	EUDELL L. CUNNINGHAM
1706A	MICHAEL A. LECKLITER
1707A	HECTOR MAGALLANES
1708A	RICHARD E. JOHNSON
1709A	PAUL G. HARTWELL

* Granted SCD – Employer Cannot Accommodate

VIII. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

General Members
Service-Connected Disability Applications

On a motion by Mr. Chery, seconded by Ms. Gray, the Board of Retirement approved a service-connected disability retirement for the following named employees who were found to be disabled for the performance of their duties and have met the burden of proof:

APPLICATION NO.	NAME
2558B	CELIA M. MOURLOT
2559B	CYNTHIA A. WESLEY
2560B	STEPHEN M. DERRY
2561B*	SILVIA M. HOFAWGER
2562B*	AUDREY M. BIRD
2563B**	EDWARD G. BROWN
2564B***	EDNA EVAZYAN

* Granted SCD – Salary Supplemental
** Granted SCD – Employer Cannot Accommodate
*** Granted SCD – Retroactive with a 2 Year Review

IX. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability

Chair Kehoe requested that the Board handle those cases that were

Pulled off the Consent Calendar first.

APPLICATION NO. & NAME	BOARD ACTION
390C – CYNTHIA A. BERCIAN	Mr. Bernstein made a motion, Ms. Gray seconded, to grant a service connected disability retirement with a two year review pursuant to Government Code Section 31720 since the employer cannot accommodate. Mr. Muir made a substitute motion, Ms. Gray seconded, to grant a service connected disability retirement without a two year review pursuant to Government Code Section 31720 since the employer cannot accommodate. The motion passed with Mr. Bernstein voting no.
6843A – ROLAND K. JACKSON	Mr. de la Garza made a motion, Mr. Okum seconded, to deny a service connected disability retirement and find the applicant not permanently incapacitated. The motion passed unanimously.
6844A – MARY F. MARSH*	Mr. de la Garza made a motion, Mr. Okum seconded, to grant a non-service connected disability retirement pursuant to Government Code Section 31720. The motion passed unanimously.

* Applicant Present

IX. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability (Continued)

APPLICATION NO. & NAME	BOARD ACTION
2434B – BARBARA L. BARBERO*	Mr. de la Garza made a motion, Mr. Okum seconded, to deny a service connected disability retirement and find the applicant not permanently incapacitated. The motion passed unanimously.
6470A – PATRICIA L. HALL-JACOBS	Mr. Okum made a motion, Mr. Muir seconded, to grant a non-service connected disability retirement and grant the option for earlier effective date pursuant to Government Code Sections 31720 and 31724. The motion passed unanimously. (Mr. Pryor arrived at 9:19 a.m.)
6821A – ROSARIO PEREZ	Chair Kehoe made a motion, Mr. Bernstein seconded, to grant a non-service connected disability retirement pursuant to Government Code Section 31720. The motion passed unanimously.

* Applicant Present

IX. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

B. Referee Reports

APPLICATION NO. & NAME	BOARD ACTION
Rick W. Craigo – Michael Treger for applicant Allison E. Barrett for respondent	Chair Kehoe made a motion, Mr. Chery seconded, to grant a service connected disability retirement and find the applicant disabled. The motion passed unanimously.
Dennis E. Cusino – Michael Treger for applicant Allison E. Barrett for respondent	Mr. Okum made a motion, Mr. Chery seconded, to deny the option of an earlier effective date. Mr. Bernstein made a substitute motion, Chair Kehoe seconded, to refer back to staff for additional information. The motion passed unanimously.
Terence P. Judge – Michael Treger for applicant Steven Tallant for respondent	Chair Kehoe made a motion, Mr. Bernstein seconded, to grant a service connected disability retirement with an option of an earlier effective date. The motion passed unanimously.

IX. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

B. Referee Reports (Continued)

APPLICATION NO. & NAME	BOARD ACTION
Henry W. Jansen III – Thomas J. Wicke for applicant Steven Tallant for respondent	Mr. Chery made a motion, Mr. Okum seconded, to deny a service connected disability retirement and find the applicant not disabled. Mr. Bravo made a substitute motion, Chair Kehoe seconded, to refer back to staff for additional information. The motion passed (roll call) with Messrs. Bravo, Okum, Robbins, de la Garza, Chery, Ms. Gray, and Chair Kehoe voting yes; and Mr. Bernstein voting no.
Adwoa Appiah – Steven R. Pingel for applicant Eugenia W. Der for respondent	Mr. Chery made a motion, Chair Kehoe seconded, to grant a service connected disability retirement and find the applicant disabled. The motion passed unanimously.
Nubar Chalikian, Dec'd – Thomas J. Wicke for applicant Mary A. Chalikian, Surv. Eugenia W. Der for respondent	(Mr. Robbins left the Boardroom at 10:20 a.m.) Mr. de la Garza made a motion, Mr. Chery seconded, to grant the

IX. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

B. Referee Reports (Continued)

APPLICATION NO. & NAME	BOARD ACTION
Nubar Chalikian, Dec'd – (Continued)	continuation of non-service connected survivor death benefits. Mr. Chery made a motion, Ms. Gray seconded, to refer back to staff for additional information. The motion passed (roll call) with Messrs. Bravo, Chery, Ms. Gray, and Chair Kehoe voting yes; and Messrs. Bernstein, Okum, and de la Garza voting no.

C. Staff Recommendations

1. Recommendation as submitted by JJ Popowich, Assistant Executive Officer: That the Board approve the service provider invoice for Gutierrez, Preciado & House, LLP. (Memo dated September 23, 2015)

John Popowich was present to address questions from the Board.

Mr. Chery made a motion, Mr. Muir seconded, to approve the recommendation. The motion passed unanimously.

Due to high costs, Chair Kehoe urged staff to properly evaluate cases being referred to outside counsel.

(Mr. Robbins returned to the Boardroom at 10:20 a.m.)

IX. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

C. Staff Recommendations (Continued)

2. Recommendation as submitted by Francis J. Boyd, Senior Staff Counsel, Legal Division: That the Board reject Steven K. Christensen's request to file a late appeal of the Board of Retirement's August 16, 2013 decision because the Board has no legal authority to consider or reopen this decision. (Memo dated September 25, 2015)

Francis J. Boyd was present to address questions from the Board.

Mr. Chery made a motion, Mr. de la Garza seconded, to approve the recommendation. The motion passed unanimously.

X. EXECUTIVE SESSION

A. Conference with Legal Counsel - Pending Litigation
(Pursuant to Paragraph (1) of Subdivision (d) of California Government Code Section 54956.9)

1. Marina Wingenbach v. LACERA, et al.
Los Angeles Superior Court Case No. BC 593615

The Board met in Executive Session pursuant to Government Code Section 54956.9 in which there is nothing to report at this time.

2. Gloria Arellanes v. Board of Retirement

The Board met in Executive Session pursuant to Government Code Section 54956.9 in which there is nothing to report at this time.

Green Folder Information (Information distributed in each Board Members Green Folder at the beginning of the meeting)

1. Retirement Board Listing dated October 7, 2015

XI. ADJOURNMENT

There being no further business to come before the Board, the meeting was adjourned at 11:50 a.m.

_____
WILLIAM DE LA GARZA, SECRETARY

_____
SHAWN R. KEHOE, CHAIR

MINUTES OF THE REGULAR MEETING OF THE BOARD OF RETIREMENT

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA

9:00 A.M., THURSDAY, OCTOBER 15, 2015

PRESENT: Shawn R. Kehoe, Chair

Alan Bernstein, Vice Chair (Arrived at 9:13 a.m.)

William de la Garza, Secretary

Anthony Bravo

Yves Chery

Vivian H. Gray (Arrived at 9:08 a.m.)

Joseph Kelly

David L. Muir (Alternate Retired)

William Pryor (Alternate Member)

Ronald A. Okum

Les Robbins

STAFF ADVISORS AND PARTICIPANTS

Gregg Rademacher, Chief Executive Officer

JJ Popowich, Assistant Executive Officer

Steven Rice, Chief Counsel

Fern M. Billingy, Senior Staff Counsel

Barry W. Lew, Legislative Affairs Officer

I. CALL TO ORDER

The meeting was called to order by Chair Kehoe at 9:00 a.m., in the Board Room of Gateway Plaza.

II. PLEDGE OF ALLEGIANCE

Mr. Chery led the Board Members and staff in reciting the Pledge of Allegiance.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of September 10, 2015

Mr. de la Garza made a motion, Mr. Chery seconded, to approve the minutes of the regular meeting of September 10, 2015. The motion passed unanimously.

IV. REPORT ON CLOSED SESSION ITEMS

There was nothing to report at this time.

V. OTHER COMMUNICATIONS

A. For Information

1. Awards

Mr. Rademacher recognized several Board members for their service on LACERA's Boards. Mr. William Pryor was recognized for his term ending in 2013 on the Board of Retirement and Board of Investments, Messrs. Chery and Okum were recognized for term ending in 2014 on the Board of Retirement, and Mr. Kehoe was recognized for his term ending in 2013 on the Board of Retirement.

V. OTHER COMMUNICATIONS

A. For Information

1. Awards (Continued)

In addition, Mr. Rademacher presented Rosalind White with an award for her 40 Years of Service.

Lastly, Mr. Rademacher presented an award to Mary Arenas, Joie Dang, Laura Delgado, Teresa Demara, Xue-Mei Gao, Christian Perez, Fabio Ramirez, Gersom Salmeron, Rebecca Sun, Christina Tung, Letha Williams-Martin and Alexandra Hollis for successfully completing the LACERA University Core Benefits Course of 2015. Mr. Rademacher also recognized Quality Assurance trainers, Nora Jackson, Arlene Owens, Dana Brooks, Phuong Reyes, Melissa Salazar and Sevan Simonian and Alisa Gavaller who supervised and mentored these individuals during their training.

2. August 2015 All Stars

Mr. Popowich announced the eight winners for the month of August: Cynthia Juvinall, Debbie Semnanian, Amy Tao, Linda Moss, Anh Tu-Huynh, Donna Hansen, Valery Ptacek, and Andrea Ellison for the Employee Recognition Program and Tamara Caldwell for the Webwatcher Program. Chona Labtic-Austin, Kyona Dunbar, Gena Fuller, and Van Bonifacio were the winners of LACERA's RideShare Program.

V. OTHER COMMUNICATIONS (Continued)

3. Chief Executive Officer's Report
(Memo dated October 6, 2015)

Mr. Rademacher provided a brief overview of his Chief Executive Officer's Report with a quick update on what transpired at the previous Board of Investments meeting. (Board of Investments minutes are available to view on LACERA's Website www.lacera.com.)

Mr. Rademacher updated the Board regarding the revisions to the Voters Empowerment Act of 2016.This ballot measure has been replaced with two new ballot initiatives called the Voters Empowerment Initiative and the Government Pension Cap Act. Details on these two new initiatives will be presented to the Board in November.

Mr. Rademacher shared with the Board that Los Angeles County has reached a tentative agreement with SEIU. The agreement includes salary increases, an increase in County contribution for medical premiums, additional vacation accrual for long-term employees, and a new paid holiday.

In addition, retired LACERA members will be receiving a letter from RELAC sharing the benefits of joining the organization.

Mr. Rademacher announced that the Board of Supervisors approved to amend the County's salary ordinance. Mr. Rademacher thanked Mr. Kelly for his help in communicating the details of this item with the Board of Supervisor's staff.

V. OTHER COMMUNICATIONS

3. Chief Executive Officer's Report (Continued)

Lastly, Mr. Rademacher reminded the Board that the next meeting will be a joint Board of Retirement meeting on Wednesday, November 4, 2015.

VI. PUBLIC COMMENT

Katherine H. Edwards addressed the Board regarding her administrative appeal on the agenda, Item VIII. A. 1.

VII. NON-CONSENT AGENDA

A. Recommendation as submitted by the Ad Hoc Fiduciary Counsel Selection Committee: That the Board retain Nossaman LLP, Reed Smith LLP, and Olson Hagel & Fishburn LLP as fiduciary counsel.
(Memo dated October 2, 2015)

Mr. Muir made a motion, Ms. Gray seconded, to approve the recommendation. The motion passed unanimously.

B. Recommendation as submitted by Gregg Rademacher, Chief Executive Officer: That the Board review the 2015 meeting schedule and consider rescheduling the Thursday, December 10, 2015 meeting.
(Memo dated September 10, 2015)

Mr. Chery made a motion, Chair Kehoe seconded, to reschedule the Thursday, December 10, 2015 Administrative meeting to Wednesday, December 2, 2015. This meeting will include both Administrative and Disability agenda items. The motion passed unanimously.

VIII. EXECUTIVE SESSION

A. Conference with Legal Counsel - Anticipated Litigation
Significant Exposure to Litigation Pursuant to Paragraph (2) of Subdivision (d) of California Government Code Section 54956.9

1. Administrative Appeal of Katherine H. Edwards

The Board met in Executive Session pursuant to Paragraph (2) of Subdivision (d) of Government Code Section 54956.9 in which the Board unanimously voted to deny the appeal.

2. Case

Prior to going into Executive Session, Mr. Rice requested that the Board entertain a motion for approval to discuss a potential claim and anticipated litigation not on the posted agenda pursuant to Government Code Sections 54954.2 Subdivision B and 54956.9, Paragraph 2 of Subdivision D. This would permit the Board to meet in Closed Session to take action on a matter not on the posted agenda if it finds there is a need for immediate action and the immediate action came into contention after the agenda was posted. These two criteria were met.

Mr. Bernstein made a motion, Ms. Gray seconded, to make the required findings and approve the request. The motion passed unanimously.

The Board met in Executive Session pursuant to Government Code Section 54956.9 (D)(2) to discuss anticipated litigation. The Board provided instructions to Legal counsel.

VIII. EXECUTIVE SESSION (Continued)

B. Pursuant to Government Code Section 54957 - Public Employee Performance Evaluation:

1. Performance Evaluation
Title: Chief Executive Officer

The Board met in Executive Session pursuant to Government Code Section 549567 in which there is nothing to report at this time.

IX. GOOD OF THE ORDER
(For information purposes only)

There was nothing to report during the Good of the Order.

Green Folder Information (Information distributed in each Board Members Green Folder at the beginning of the meeting)

1. LACERA Legislative Report - Bills Amending CERL/PEPRA (Dated October 14, 2015)

2. Report on Meeting with Legislative Consultants on September 18, 2015 (For Information Only) (Memo dated October 13, 2015)

X. ADJOURNMENT

There being no further business to come before the Board, the meeting was adjourned at 12:40 p.m.

_____
WILLIAM DE LA GARZA, SECRETARY

_____
SHAWN R. KEHOE, CHAIR

October 27, 2015

TO: Each Member
Board of Retirement
Board of Investments

FROM: Gregg Rademacher
Chief Executive Officer

SUBJECT: **CHIEF EXECUTIVE OFFICER'S REPORT**

I am pleased to present the Chief Executive Officer's Report that highlights a few of the operational activities that have taken place during the past month, key business metrics to monitor how well we are meeting our performance objectives, and an educational calendar.

Management Offsite

On October 20-21, 2015, we held our annual Management Offsite. The Offsite is an opportunity for the management team to get together to discuss LACERA's future; work on our team building and personal development. Each year we try to focus on a different aspect of managing the organization to deliver on our mission to Produce, Protect, and Provide the Promised Benefits. This year we invited the Virtual CEO Group to present their Energize2Lead program. This program provides insight into the "how" and "why" in our communication styles. The program provides insight into three different areas: Preferred Style – our default or natural way we like to communicate, the Instinctive Style – the style we adopt when under stress, and the General Expectations that we have for others that communicate with us. The Virtual CEO Group walked us through the results and provided insights into how the management team can communicate better by understanding the communication styles of their peers. One message we all took away from this session was LACERA benefits from the strength of our diversification. For example, one leader's strength may be in asking the "why" questions, another leader's strength may be building a consensus, while yet another may be stronger in communicating the "how" we'll complete a project or goal. The end result is a team with complimenting strengths leading to more successful results. The Virtual CEO Group will be back later this year to provide another round of management training.

The team also had a robust discussion about possible objectives for the upcoming 2016-2017 Strategic Plan. These objectives will be blended with direction from your Board as we develop the upcoming Strategic Plan for your approval.

New Core Benefits Training Class

We are excited to announce we will be starting our 7th Core Benefits Training program in November. The Core Benefits Training program is a rigorous year long training regime including a mix of classroom instruction, testing, detailed case analysis, case discussion, and real-time production experience. Throughout training, 100% of their work product is checked for quality and feedback is provided in a very collegial learning environment.

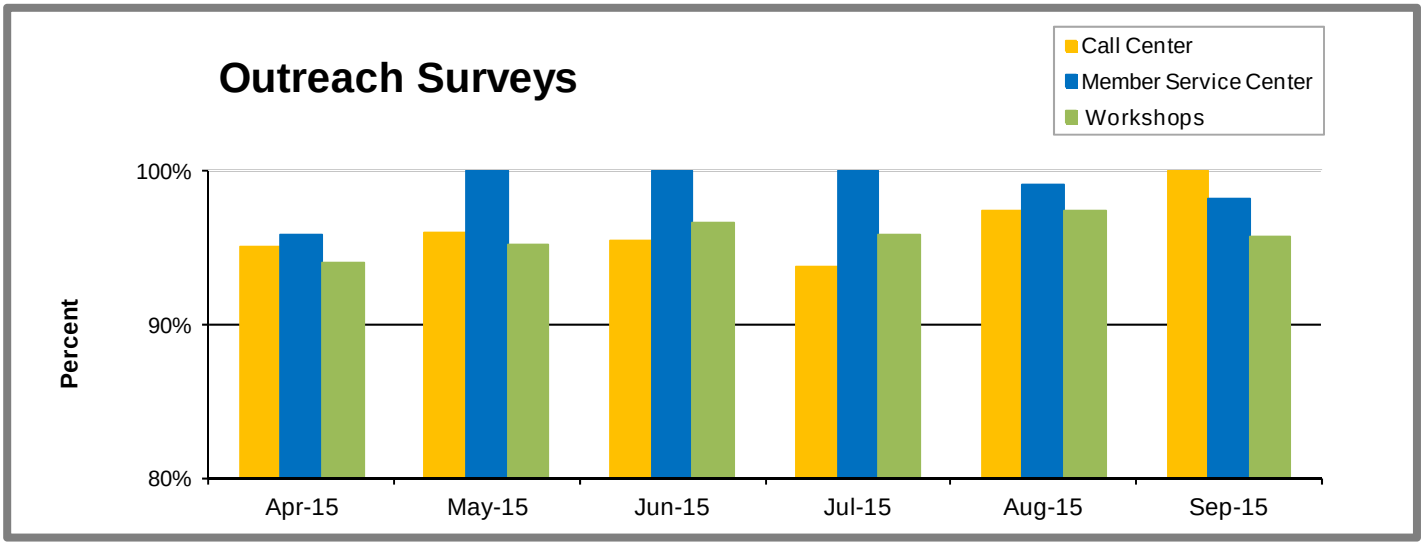
We are in the final stages of the selection process for this class but we expect to have somewhere between 12-16 new hires and veteran staff members. The training program also includes the development of the future leadership team of LACERA. In addition to the trainees, two staff are assigned to act as group supervisors. These supervisors are often veteran staff who are developing their leadership skills. Together, the teams grow and learn not only the technical aspects of what we do but also about themselves and what makes LACERA a successful organization.

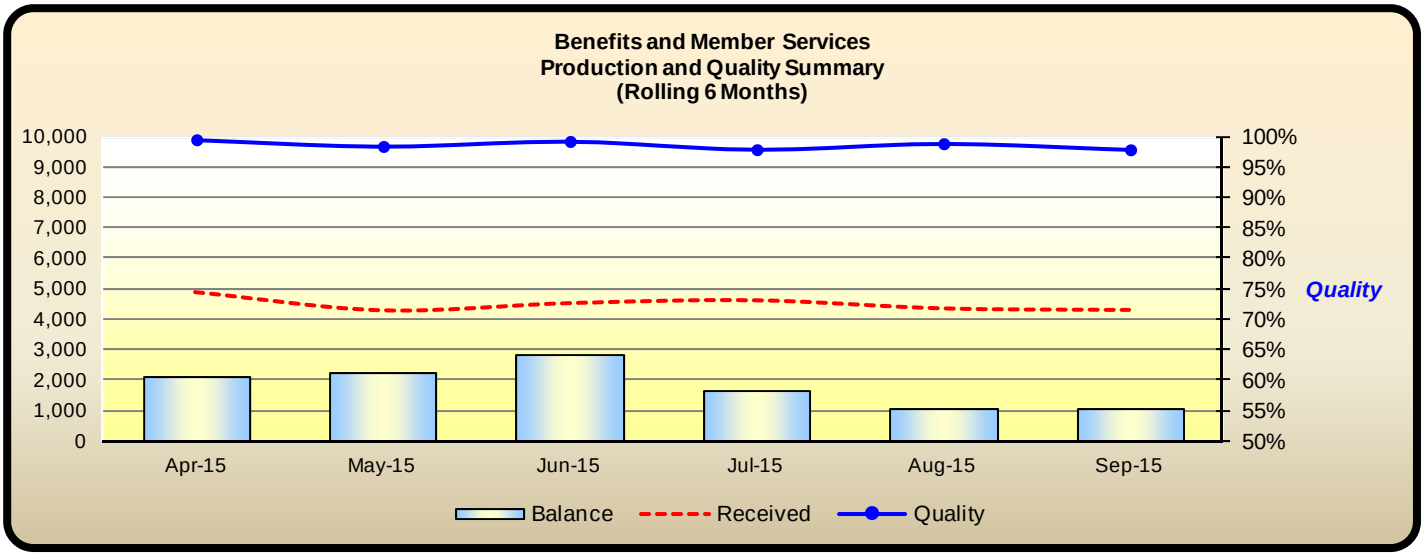
GR: JP
CEO report Nov 2015.doc

Attachments

LACERA's KEY BUSINESS METRICS

OUTREACH EVENTS AND ATTENDANCE				
Type	**# of WORKSHOPS**		**# of MEMBERS**	
	Monthly	**YTD**	**Monthly**	**YTD**
Benefit Information	14	48	662	1,709
Mid Career	2	2	35	35
New Member	13	49	289	1,009
Pre-Retirement	12	25	302	586
General Information	2	4	12	262
Retiree Events	1	1	30	30
Member Service Center	Daily	Daily	1,352	4,346
TOTALS	**44**	**129**	**2,682**	**7,977**





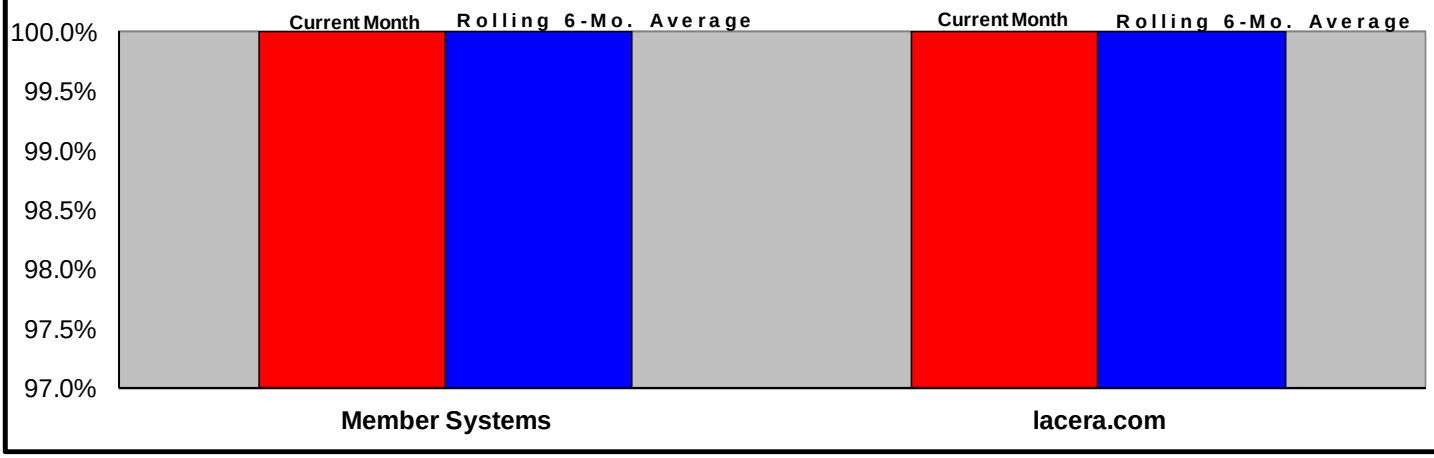
Member Services Contact Center			RHC Call Center	Top Calls
Overall Key Performance Indicator (KPI)	100.73%			
Category	**Goal**	**Rating**		
Call Center Monitoring Score	95%	97.63%	98%	Member Services
Grade of Service (80% in 60 seconds)	80%	73%	61%	**1)** Workshop Information/Appt.: Inquiries
Call Center Survey Score	90%	100.00%	xxxxx	**2)** Retirement Counseling: Estimate
Agent Utilization Rate	65%	68%	73%	**3)** Benefit Payments: Gen. Inquiry/Payday
Number of Calls		9,634	3,405	Retiree Health Care
Calls Answered		9,062	3,170	**1)** Medical Benefits-General Inquiries
Calls Abandoned		572	242	**2)** Medical-New Enroll/Change/Cancel
Calls-Average Speed of Answer		62 Sec.	01:36	**3)** Turning Age 65/Part B Prem Reimburse
Number of Emails		255	170	
Emails-Average Response Time		21:07	1	Adjusted for weekends

LACERA's KEY BUSINESS METRICS

Fiscal Years	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Assets-Market Value	$32.0	$35.2	$40.9	$38.7	$30.5	$33.4	$39.5	$41.2	$43.7	$51.1
Funding Ratio	85.8%	90.5%	93.8%	94.5%	88.9%	83.3%	80.6%	76.8%	75.0%	79.5%
Investment Return	11.0%	13.0%	19.1%	-1.4%	-18.2%	11.8%	20.4%	0.3%	12.1%	16.8%

DISABILITY INVESTIGATIONS						
APPLICATIONS	**TOTAL**	**YTD**		**APPEALS**	**TOTAL**	**YTD**
On Hand	465	xxxxxxx		On Hand	192	xxxxxxx
Received	34	114		Received	5	15
Re-opened	0	1		Administratively Closed	1	5
To Board – Initial	32	102		Referee Recommendation	3	7
Closed	4	14		Revised/Reconsidered for Granting	0	4
In Process	**463**	**463**		**In Process**	**193**	**193**

SYSTEMS AVAILABILITY SEPTEMBER 2015



Active Members as of 10/26/15	
General-Plan A	296
General-Plan B	109
General-Plan C	105
General-Plan D	48,052
General-Plan E	21,730
General-Plan G	11,595
Total General	**81,887**
Safety-Plan A	14
Safety-Plan B	11,640
Safety-Plan C	808
Total Safety	**12,462**
TOTAL ACTIVE	**94,349**

Retired Members/Survivors as of 10/26/15	Retirees	Survivors	Total
General-Plan A	19,928	4,786	24,714
General-Plan B	679	59	738
General-Plan C	419	54	473
General-Plan D	10,873	1,035	11,908
General-Plan E	10,499	834	11,333
General-Plan G	1	0	1
Total General	**42,399**	**6,768**	**49,167**
Safety-Plan A	5,978	1,573	7,551
Safety-Plan B	3,955	212	4,167
Safety-Plan C	1	0	1
Total Safety	**9,934**	**1,785**	**11,719**
TOTAL RETIRED	**52,333**	**8,553**	**60,886**

Retired Members	
Monthly Payroll	240.55 Million
Payroll YTD	721.24 Million
Monthly Added	266
Seamless %	100.00
YTD Added	850
Seamless YTD %	100.00
Direct Deposit	95%

Health Care Program (YTD Totals)	Employer Amount	Member Amount
Medical	109,037,137	9,711,216
Dental	9,156,490	983,975
Med Part B	12,237,225	xxxxxxxxxx
Total Amount	**$130,430,852**	**$10,695,191**

Health Care Program Enrollments	
Medical	46,755
Dental	47,699
Med Part B	30,088
Long Term Care (LTC)	780

Funding Metrics as of 6/30/14	
Employer Normal Cost	9.29%
UAAL	10.04%
Assumed Rate	7.50%
Star Reserve	$614 million
Total Assets	$47.7 billion

Member Contributions as of 6/30/14	
Annual Additions	$439 million
% of Payroll	6.08%

Employer Contributions as of 6/30/14	
Annual Addition	$1,320 million
% of Payroll	19.33%

Date	Conference
November, 2015	
3-4	ACGA 15th Annual Conference Kuala Lumpur, Malaysia
3-5	AVCJ's (Asian Adventure Capital Journal) 28th Annual Private Equity & Venture Forum Hong Kong, China
4-5	Institutional Limited Partners Association (ILPA) General Partner Summit New York, NY
4-5	15th Annual Goldman Sachs Asset Management (GSAM) Symposium New York, NY
8-11	IFEBP (International Foundation of Employment Benefit Plans) Annual Employee Benefits Conference Honolulu, HI
16-18	AHIP (America's Health Insurance Plans) Fall Forum 2015 Phoenix, AZ
17-20	SACRS San Diego, CA
December, 2015	
1-2	AVCJ's 16th Annual Private Equity & Venture Forum Mumbai, India
8	Milken Institute Summit – California Los Angeles, CA
10	2015 Energy Game Change Conference Houston, TX
January, 2016	
24-26	NCPERS (National Conference on Public Employee Retirement Systems) Legislative Conference Washington D.C.
February, 2016	
3-5	IMN (Information Management Network) Annual Beneficial Owners' international Securities Lending Conference Phoenix, AZ
24-26	Pacific Pension Institute (PPI) North American Winter Roundtable Rancho Palos Verdes, CA
March, 2016	
14-16	IFEBP (International Foundation of Employment Benefit Plans) Investments Institute Las Vegas, NV

DATE: October 23, 2015

TO: Each Member
Board of Retirement

FROM: Ricki Contreras, Division Manager
Disability Retirement Services

SUBJECT: **APPEALS FOR THE BOARD OF RETIREMENT'S MEETING OF NOVEMBER 4, 2015**

IT IS RECOMMENDED that your Board grant the appeals and requests for administrative hearing received from the following applicants and direct the Disability Retirement Services Manager to refer each case to a referee:

6832A	Lekeisa Washington	Mark E. Singer	Deny SCD - Not disabled
6688A	Joseph P. Ruggiero Jr.	In Pro Per	Grant SCD - Appealing retroactive effective date only
6827A	Bertha F. Luna	In Pro Per	Deny SCD – Grant NSCD

Newapp.doc
November 4, 2015

October 22, 2015

TO: Each Member
Board of Retirement

FROM: Ricki Contreras, Manager
Disability Retirement Services Division

FOR: November 4, 2015 Board of Retirement Meeting

SUBJECT: **DISMISS WITH PREJUDICE THE APPEAL OF ERIC L. BUEGE**

Mr. Eric L. Buege applied for a service-connected disability retirement on July 10, 2014. On August 5, 2015, the Board granted his application for a service-connected disability retirement.

Mr. Buege's attorney filed a timely appeal regarding the effective date of Mr. Buege's service-connected disability retirement. On October 19, 2015, the applicant's attorney advised LACERA that his client did not wish to proceed with his appeal.

IT IS THEREFORE RECOMMENDED THAT YOUR BOARD:

Dismiss with prejudice Eric L. Buege's appeal for an earlier effective date.

FJB: RC: sc

Buege, Eric L.doc

Attachment

NOTED AND REVIEWED:

Francis J. Boyd, Sr. Staff Counsel

Date: 10/22/15

October 22, 2015

TO: Each Member
Board of Retirement

FROM: Ricki Contreras, Manager RC
Disability Retirement Services Division

FOR: November 4, 2015 Board of Retirement Meeting

SUBJECT: **DISMISS WITH PREJUDICE THE APPEAL OF ROBERTO C. SURIA VAZQUEZ**

Mr. Roberto C. Suria Vazquez applied for service-connected disability retirement on November 11, 2013. On July 1, 2015, the Board denied his application for service-connected disability retirement.

Mr. Roberto C. Suria Vazquez filed a timely appeal. On October 15, 2015, Mr. Suria Vazquez signed a voluntary withdrawal letter advising LACERA that he does not wish to proceed with his appeal.

IT IS THEREFORE RECOMMENDED THAT YOUR BOARD:

Dismiss with prejudice Roberto C. Suria Vazquez's appeal for service-connected disability retirement.

FJB: RC: sc

Suria Vazquez, Roberto C.doc

Attachment

NOTED AND REVIEWED:

Francis J. Boyd, Sr. Staff Counsel

Date: 10/22/15

LACERA

October 13, 2015

TO: Each Member
Board of Retirement

FROM: Disability Procedures & Services Committee
Vivian H. Gray, Chair
William de la Garza, Vice Chair
William R. Pryor
Les Robbins
Yves Chery, Alternate

FOR: November 4, 2015 Board of Retirement Meeting

SUBJECT: **CONSIDER APPLICATION(S) FOR LACERA PANEL OF EXAMINING PHYSICIAN(S)**

On October 7, 2015, the Disability Procedures & Services Committee reviewed the attached applications for the LACERA Panel of Examining Physicians.

The application packages have been reviewed by the Committee. After discussion, the Committee voted to accept the applications of the following physicians and submit to the Board of Retirement for approval to the LACERA panel.

IT IS THEREFORE RECOMMENDED THAT the Board approve the following physicians to the LACERA Panel of Physicians for the purpose of examining disability retirement applicants.

Kenneth P. Scheffels, M.D. – Board Certified Orthopedist

Thomas W. Fell, Jr., M.D. – Board Certified Orthopedist

Attachments

VG:RC/sc

September 23, 2015

TO: Disability Procedures & Services Committee
Vivian H. Gray, Chair
William de la Garza, Vice Chair
William R. Pryor
Les Robbins
Yves Chery, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services Division

FOR: October 7, 2015, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF KENNETH P. SCHEFFELS, M.D., AS LACERA PANEL PHYSICIAN**

On August 17, 2015, Debbie Semnanian interviewed Kenneth P. Scheffels, M.D., a physician seeking appointment to the LACERA Panel of Examining Physicians.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s).

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of Kenneth P. Scheffels, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJ:RC/sc

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

Date: 9/24/15

August 17, 2015

TO: **Ricki Contreras, Division Manager**
Disability Retirement Services

FROM: **Debbie Semnanian, WCCP** DS
Supervising Disability Retirement Specialist

SUBJECT: **INTERVIEW OF ORTHOPEDIC SURGEON APPLYING FOR LACERA PHYSICIAN'S PANEL**

On August 17, 2015, I interviewed **Kenneth Scheffels**, M.D. at his office at 4940 Van Nuys Blvd., Suite 302, Sherman Oaks, CA 91403. The office space is located in an older but well maintained three-story building with patient paid parking (maximum $6.00) located in the back of the building. There is also free 2-hour parking on the adjacent street.

Dr. Scheffels is a board certified orthopedic surgeon who has been in private practice for over forty years. Dr. Scheffels shares office space with several orthopedists and a neurologist. He has available 6 complete examination rooms. Dr. Scheffels estimates that 30 percent of his practice is devoted to patient treatment, while the other 70 percent of his time is devoted to IME evaluations primarily within the workers' compensation systems and another retirement system.

As referenced in his Curriculum Vitae, Dr. Scheffels graduated from New York Medical College, where he also completed an internship and residency. He has served as the former Chairman of the Department of Surgery and on the Credentials and Ethics Committee at Pacifica of the Valley Hospital.

Dr. Scheffels's office was clean with adequate seating. The office and restrooms are handicap accessible and there is a staff of thirteen employees.

Staff reviewed the LACERA Disability Retirement procedures and expectations in its evaluation of County Employees applying for both service-connected and nonservice-connected disability retirements. The importance of preparing impartial and non-discriminatory reports that are clear and concise and address issues of causation and incapacity were discussed with the doctor. He understood that he would adhere strictly to the HIPAA laws that would also apply for LACERA reports. Staff reviewed with Dr. Scheffels the Panel Physician Guidelines for evaluating LACERA applicants and defined the relationship between workers' compensation and disability retirement. Staff discussed the

need to rely on his own objective and subjective findings rather than the opinions of previous physician reports and/or comments.

Dr. Scheffels agreed to adhere to LACERA's standard of having his evaluation reports sent to us within 30 days of examination. Staff confirmed that Dr. Scheffels is agreeable with accepting payment per the Official Medical Fee Schedule (OMFS). Dr. Scheffels was informed that if he is approved by the Board to be on our panel of physicians, he is required to contact the specialist assigned to the case for approval of any special tests or extraordinary charges. He was also informed that a Quality Control Questionnaire is sent to each applicant regarding their visit.

RECOMMENDATION

LACERA has a pressing need to add orthopedic physicians, particularly in the area in which Dr. Scheffels completes examinations. He expressed not only a willingness to be on our panel, but also an enthusiasm for building a relationship with LACERA.

Based on our interview and the need for his specialty, staff recommends Dr. Scheffels' application be presented to the Board for approval as a LACERA Panel Physician.

LACERA

Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-2419 • 800/786-6464

GENERAL INFORMATION		Date 6-24-15
Group Name:		Physician Name: Kenneth P. Scheffels MD
I.	Primary Address: 4940 Van Nuys Blvd #302, Sherman Oaks CA 9140	
	Contact Person Marc Bautzer	Title Marketing Rep.
	Telephone: 818-990-4497	Fax 818-990-6045.
II.	Secondary Address See Attached List.	
	Contact Person E. Moss	Title Administrator
	Telephone 818-990-4497	Fax 818-9906045

PHYSICIAN BACKGROUND		
Field of Specialty Orthopedic Surgery	Subspecialty ~~Spine~~	
Board Certification ☒ Yes ☐ No	License # G29461	Expiration Date 8-31-16.

EXPERIENCE
Indicate the number of years experience that you have in each category.

Evaluation Type

I. Workers' Compensation Evaluations

☑ Defense	How Long?	20 yrs.	☑ IME	How Long?	10 yrs
☐ Applicant	How Long?	5 yrs	☑ QME	How Long?	20 yrs.
☑ AME	How Long?	10 yrs			

No hrs

II. ☑ Disability Evaluations How Long? 20 yrs.

For What Public or Private Organizations? Federal Defense Base;

Currently Treating? ☑ Yes ☐ No

Time Devoted to: Treatment 30% Evaluations 70%

Estimated Time from Appointment to Examination	Able to Submit a Final Report in 30 days?
☐ 2 weeks ☑ 3-4 Weeks ☐ Over a month	☒ Yes ☐ No

LACERA's Fee Schedule	
Examination and Initial Report by Physician	$1,500.00 flat fee
Review of Records by Physician	$350.00/hour
Review of Records by Registered Nurse	$75.00/hour
Supplemental Report	$350.00/hour

-OVER-

Other Fees	
Physician's testimony at Administrative Hearing (includes travel & wait time)	$350.00/hour
Deposition Fee at Physician's office	$350.00/hour
Preparation for Expert Testimony at administrative Hearing	$350.00/hour
Expert Witness Fees in Superior or Appellate Court	$3,500.00 half day $7,000 full day

Physician agrees with LACERA's fee schedule? Yes No

Comments

Name of person completing this form:

Kenneth P. Scheffels MD. Title: MD

(Please Print Name)

Physician Signature: [signature] Date: 6-18-15

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date: 8/17/15	Interview Time: 12:00
Interviewer: Debbie Swanson	

Kenneth P. Scheffels, M.D.
Orthopedic Surgery

CURRICULUM VITAE

EDUCATION:

NEW YORK MEDICAL COLLEGE, NEW YORK - M.D. DEGREE
METROPOLITAN HOSPITAL MEDICAL CENTER IN AFFILIATION WITH NEW YORK MEDICAL COLLEGE, NEW YORK - INTERNSHIP
NEW YORK MEDICAL COLLEGE, NEW YORK - RESIDENCY

LICENSES AND CERTIFICATIONS:

M.D. LICENSE - CALIFORNIA AND NEW YORK
DIPLOMATE, AMERICAN BOARD OF ORTHOPEDIC SURGERY
QUALIFIED MEDICAL EVALUATOR (QME)

MEMBERSHIPS AND SOCIETIES:

LOS ANGELES COUNTY MEDICAL ASSOCIATION - PAST MEMBER OF THE BOARD OF DIRECTORS
CALIFORNIA MEDICAL ASSOCIATION
AMERICAN MEDICAL ASSOCIATION

HOSPITAL APPOINTMENTS:

PACIFICA OF THE VALLEY HOSPITAL - FORMER CHAIRMAN DEPARTMENT OF SURGERY; CREDENTIALS AND ETHICS COMMITTEE

HONORS AND AWARDS:

NEW YORK MEDICAL COLLEGE SURGICAL SOCIETY AWARD - 1969

EXPERIENCE:

PRIVATE PRACTICE OF ORTHOPEDIC SURGERY, (MED HEALTH) 1988-PRESENT
SERRA MEDICAL CLINIC, 1978-2003
ROSS-LOOS, LOS ANGELES, 1975-1978

SAMPLE

KENNETH P. SCHEFFELS, M.D.

Diplomate, American Board of Orthopedic Surgery

630 W. Duarte Road, Suite 203
Arcadia, California 91007
(626) 447-8870

#1

[redacted]

[redacted]

Attn: XXXXXXXXX XXXXXXXX, [redacted]

- and -

[redacted]

Attn: XXXXXXX XXXXX, [redacted]

RE: XXXXXXXXX [redacted] GXXXXXX vs. [redacted]

CLAIMANT : XXXXXXXXX [redacted]
CLAIM NO : XXXXXXXXXX
EAMS NO : ADJXXXXX
EMPLOYER : XXXXXX XXXXX, DDS
ACCT. NO : [redacted]
D/INJURY :
D/EXAMIN :

ORTHOPEDIC PANEL QME EVALUATION REPORT

Dear Ms. XXX and Mr. HXXXXXXX:

Today, I had the opportunity to perform an orthopedic Panel QME evaluation in my Arcadia office on XXXXXX [redacted] a 50-year-old, right-handed female. She gives the following history.

This is a Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances (ML104), of nine and one-half hours in length. This is a QME evaluation and extensive medical records were provided. Six and one-half hours was spent on the combination of review of medical records, reviewing the depositions and in face-to-face time with the claimant. (This counts as two complexity factors). Three

[redacted]

hours spent on preparation of this report. This report addresses the issue of medical causation with written request of the parties. This report addresses the issue of apportionment, again as requested. This report also addresses the issue of, need of or modification of medical treatment.

EMPLOYMENT AT TIME OF INCIDENT:

The patient worked as a registered dental assistant, for Dr. XXXXX XXXXXX, DDS and she would assist him in his dental procedures. She worked for him for four years and worked for the previous owner of that dental office for ten years. She worked for Dr. XXXX from November of [redacted] until she was terminated in [redacted] of [redacted]. In addition to aiding him in the dental procedures, she would also do things such as pulling charts and cleaning the room and mopping the floors. Her job also involved cleaning a masking machine, which apparently is an air abrasion machine. She denied concurrent employment.

Since leaving this job she has worked for XXs, but only for one month as she could not handle the standing required. She subsequently obtained new employment part-time with a dentist in [redacted] and also has been working at XXXXXXXXX since [redacted]

HISTORY OF THE PRESENT INJURY:

The patient alleges an injury to the left hip due to her work with Dr. XXXX. However, she reports that she injured her left hip in a non-industrial slip and fall in [redacted]. Prior to that, she states that her hip was not bothering her significantly, although she had occasional aching. Since the fall, which actually took place in a bowling alley, she states that she had ongoing and increasing pain in her hip. She feels this was due to the prolonged standing at work and the arthritis that she was told that she had in the hip, was also cause by the prolonged standing at work.

She was seen by her private doctor for this hip pain, status post her slip and fall at the bowling alley, and he told her that she had significant hip disease, which the patient states initially started when she was young. She had hip

[redacted]

dysplasia as a child and did have hip surgery. Her private doctor referred her to the hip and pelvic clinic, run by Dr. XXXX. She was told that pelvic surgery would not be beneficial and that eventually, she would need a total hip replacement.

She states at that time, her back started to hurt as well. She feels that the back pain was due to the prolonged standing and when she was sitting at work, she would have to twist to reach and work on the client. She felt that this back pain started about two or three years prior to her termination.

When questioned if the back pain started prior to the hip and the fall, the patient feels she has back pain from a combination of factors, including leaning over and helping the dentist, as well as from the slip and fall from the bowling alley and her altered gait from her total hip replacement.

She reports that she has had right wrist pain for many years and felt that this developed due to her repeated use of her right hand as a dental assistant and the use of tools. She felt this started about four or five years ago.

She complains that her right foot started to hurt her around [redacted]. She feels that this was due to the fact that when she was walking and because of the hip surgery she would place her left foot on top of her right foot to relive pressure on the left hip and that caused the right foot problem.

On the recommendations of Dr. XXXX, she went to her private doctor at XXXXXXX and eventually had a total hip replacement done on [redacted] She admits that she had improvement with the surgery to the left hip, although she still reports some hip complaints.

She was also treated at XXXXXX for the right hand, with medications and therapy.

For the right foot she started treatment in [redacted] and later treated with another doctor her attorney sent her.

[redacted]

For the lumbar spine she was treated by a chiropractor, Dr. XXXX beginning in [redacted] She last treated with Dr. XXXX in [redacted] of this year.

CURRENT COMPLAINTS:

The patient has low back pain, which she indicates is present all the time and so radiation of pain into the upper thighs.

The patient has pain in the right foot with prolonged ambulation.

The patient has right wrist pain worse with repetitive grasping.

The patient has mild aching of the left hip.

Non-orthopedist complaints of stress. She states the stress has developed because Dr. XXXXX will not give her a reference.

CURRENT JOB STATUS:

The patient is working 4-hours per day as a dental assistant for a Dr. XXXXXXXXXX, 5-days per week and she works at DXXXXXXXXX in a ticket booth selling tickets part-time.

PAST MEDICAL HISTORY:

WORK INJURIES:

None prior.

ILLNESSES:

The patient has a history of type II diabetes. The patient denies any history of tuberculosis, pneumonia, or asthma. There is no history of heart disease, hypertension, epilepsy, liver disease, kidney disease, thyroid disease, ulcers, or cancer.

[redacted]

MEDICATIONS:

The patient is taking glyburide, Metformin, clarithromycin, Naproxen, amoxicillin, Tramadol and omeprazole.

ALLERGIES:

The patient is an allergy to latex.

SURGERIES:

The patient had a left hip surgery at 15-months old, as well as a left hip replacement on [redacted]

AUTO ACCIDENTS:

Many years ago, denies residuals.

FAMILY HISTORY:

The patient's mother is alive with diabetes and asthma. The patient's father is deceased from cancer.

SOCIAL HISTORY:

The patient denies the use of tobacco, but admits to drinking alcohol. The patient denies the use of illicit drugs.

REVIEW OF AVAILABLE RECORDS:

[redacted] - Cover letter from defendant's attorney (representing The XXXXXXXXX) reviewed.

UNDATED Cover letter from defendant's attorney (representing TXXXXXXXXX) reviewed.

Her ADL form was completed and reviewed.

Division of Workers Compensation:

[redacted] - Employee's claim for Workers' Compensation benefits - Date of injury listed as [redacted] Hips, back, psyche, and Internal. Signed by the patient.

[redacted]

[redacted] - Application for adjudication of claim - Date of injury listed as CT [redacted] to [redacted]. Job title: Dental Assistant. Continuous trauma injury to hips, back, nervous, and body systems. Repetitive work; overtime.

XXXXXXXXXXXXXXXX Hospital - XXXXXXX Park, California:

[redacted] - Seen for acute bronchitis. Placed on amoxicillin.

[redacted] - Seen for acute bronchitis. Placed on amoxicillin.

[redacted] - Seen for acute bronchitis. Placed on amoxicillin. Noted borderline hypertension. Assessment: Obesity. Told to exercise.

[redacted] Patient called in relating she injured her wrist on Monday, painful and stiff.

[redacted] - Seen at XXXXXX by XXXXXXXXXX XXXX, MD. *Patient fell five days ago*. Presently complains of pain across the dorsal aspect of her right wrist. Physical examination: Minimal tenderness to palpation over the dorsum of the right wrist. Assessment: Right wrist pain. X-rays showed normal right wrist. Prescribed Naprosyn.

[redacted] - X-rays of the right wrist done by B. XXX, MD - Impression: Normal x-rays of the right wrist.

[redacted] - Seen at XXXXX by XXXXX XXXXXXXX, MD for followup of right wrist pain. Recommended physical therapy.

[redacted] - Seen for URI symptoms. Reports using albuterol (Proventil). Reports taking loratadine (Claritin), Naprosyn, and pseudoephedrine.

[redacted] - Patient called in relating difficulty breathing.

[redacted] - Seen for routine eye exam. Reports blurred vision.

[redacted] - Seen for URI symptoms. Went to Las Vegas recently. Takes Naprosyn and loratadine (Claritin).

[redacted] - Seen for right ear pain times six days. Assessment: Otitis externa. Otitis media.

[redacted] - Emergency room report - Seen at XXXXX for left upper chest pain times around three days ago, radiating into her upper back. Describes sharp pain. Takes Naprosyn, loratadine (Claritin), and pseudoephedrine. Assessment: Chest pain. Recommended Baby Aspirin. Discharged in stable and ambulatory condition.

[redacted] Seen for chest pain in the emergency department. States she has been under a lot of stress since [redacted] the company she is working for had been sold. Relates she is taking care of her grandmother's trailer home. Treadmill exercise stress test performed. Pap test came back abnormal; positive for HPV.

[redacted] - Seen for colposcopy secondary to abnormal Pap smear; HPV positive.

[redacted] - Patient called in very upset; states Dr. BXXXXh has not called her with the results of her Pap smear.

[redacted] - Seen for Pap surveillance.

[redacted] - Emergency room report - Seen at XXXXX for Z-shaped laceration to volar aspect of the left index finger while cutting an avocado. Active problem list: Obesity. Abnormal Pap smear. Takes valacyclovir (Valtrex) and Naprosyn. Assessment: Status post repair of laceration. Placed on cephalexin (Keflex) and Motrin. Given wound care instructions.

[redacted] - Emergency room report - Seen at XXXXXX removal of sutures. Sustained left index finger laceration 11 days ago. Physical examination: Wound CDI. Bacitracin and Bandaid applied to left index finger. Current medications: Valacyclovir (Valtrex), Naprosyn, ibuprofen (Motrin), and cephalexin (Keflex). Given wound care instructions. Patient is discharged to home.

[redacted] - Seen by XXXXXXX XXXXXXX, MD for chronic left hip pain *for quite some time*. Had left hip surgery at 13 months

[redacted]

old; described pins were placed. Denied having surgery at age 12 or 13; states she was asymptomatic at that time. Gives history of being involved in a motor vehicle accident in 1989. Patient also complains of back pain with pain radiating from the left hip down the left leg. *Prolonged walking at XXXXXXXXXX worsens the pain.* Pain level today at 9/10. Laboratory tests showed low MPV and low vitamin D. Assessment: Left hip pain. Osteoarthritis of the hip. Status post left hip surgery at 13 months old. States pain was worse after the motor vehicle accident of [redacted] Ordered x-rays of the hip and back. Referred for orthopedic evaluation. Prescribed Vicodin. Continue Naprosyn.

[redacted]- X-rays of the left hip done by XXXXXXX XXXXXXX, MD - Impression: Osteophytes and facet hypertrophy seen in the lumbar spine. Disc space narrowing noted at L4-5 and L5-S1. Degenerative changes and disc disease of the lumbar spine.

[redacted]- Seen for followup of left hip pain times *three to four years;* worse in the past few months. States she had surgery to her hip at age [redacted] old because head of femur was not developing. *There is questionable congenital hip dysplasia.* Assessment: Obesity with BMI 33.67. Abnormal Pap smear. Prescribed Mobic. Recommended cortisone injection for the hip with XXXXXXX XXXXXXXXXXXXX, MD. Apply heat to affected areas. Told to lose weight.

[redacted] - Seen for vitamin D deficiency. Takes ergocalciferol, vitamin D2.

[redacted] - Seen for followup of hip osteoarthritis. Prescribed Celebrex.

[redacted] - Orthopedic evaluation report - Seen at XXXXXXXXXXXXXXXX XXXXXXXXX, MD for chronic left hip pain. Has had three surgeries to her hip as well as multiple episodes of casting and bracing by age [redacted] Reiterates history of motor vehicle accident approximately [redacted] years ago with increased hip pain and back pain. She did in her adolescent life; describes she was active in karate, skateboarding, and others, however she has had more pain *in the past* [redacted] *years*. Currently weighs [redacted] pounds; BMI 33.67. Describes pain in her groin and thigh. Takes Vicodin, ergocalciferol, vitamin D2, Celebrex, as well as

[redacted]

valacyclovir (Valtrex). X-rays showed left hip coxa valga with approximately 25% lateral uncovering. Moderate joint space narrowing of the left hip. Assessment: Left DDH. Congenital hip dysplasia. Hip osteoarthritis. Arthralgia of hip or thigh. Told to lose weight and minimize impact on hips. Advised high likelihood of total-hip arthroplasty. Follow up with Dr. XXXXX for possible periacetabular osteotomy. Recommended use of cane.

[redacted]- Patient called in very upset because she did not get the DMV handicap placard she requested and tomorrow she will be out of town.

[redacted]- Seen at St. XXXXXX Health Center by [redacted]XXXXX, MD for increasing left hip pain times several months, causing her to use a cane. Job title: Dental Assistant. Describes being on her feet at times at work. Past medical history: Left hip dysplasia. Past surgical history: Hip surgeries at age [redacted]months as well as [redacted]years secondary to developmental dysplasia of the hip. X-rays showed significant degree of acetabular dysplasia with a center edge angle of approximately 15° as well as evidence of moderate arthritis with decreased superior joint space, wear, and osteophytes on the femoral head with sclerosis, osteophytes, cysts, and wear of the acetabulum. Assessment: Acetabular dysplasia with arthritis of the left hip. Recommended surgery in the form of anterior-approach left total-hip replacement. Periacetabular osteotomy is not recommended.

[redacted]- PA-C spoke with patient on the phone: Patient states she cannot wait [redacted]months for surgery. Requests to have surgery with Dr. Matta. Patient will be placed on the waiting list for total-hip arthroplasty with AXXXX XXXXXXXXXXXX , MD. Patient feels she is unable to perform her job anymore.

[redacted]- Work status report - The patient is placed on total temporary disability.

[redacted]- AXXXXX KXXXXXXXXXXX, MD spoke with the patient on the phone: Same complaints of severe left hip pain greatly affecting her activities of daily living. Patient is very frustrated with the pain; declined injections and would like

[redacted]

to have her hip replaced.

[redacted]- Seen at KXXXX by AXXXXX KXXXXXXXXXXXXXXX, MD for same complaints. Dr. Matta did not recommend periacetabular osteotomy because of the degree of arthritis present; rather recommended total-hip arthroplasty. Current medications: Valacyclovir (Valtrex), Vicodin, Naprosyn, ergocalciferol, vitamin D2, and Celebrex. Same diagnoses: Left DDH with significant degenerative joint disease. Osteoarthritis of hip. Hip dysplasia, congenital. Recommended left total-hip arthroplasty.

[redacted]- Seen at XXXXXX by CXXXXXXXXX XXXX, MD for severe left hip pain as well as sleep difficulty. X-rays showed moderate to severe joint space loss with DDH of the left hip. Assessment: Left hip DDH with advanced degenerative joint disease changes. Obesity. Osteoarthritis of hip. Recommended left total-hip arthroplasty. Noted that patient is both overweight and young.

[redacted]- Seen for URI symptoms. Prescribed Medrol Dosepak and Phenergan.

[redacted]- Seen by N.P. for low back pain times six days. Gives history of motor vehicle accident in the[redacted] Last week she got up the chair and experienced back discomfort which got worse after sexual activity. Takes Vicodin for her hip and Naprosyn for her tendinitis. Assessment: Low back pain. Continue medications. Prescribed cyclobenzaprine (Flexeril).

[redacted]- Seen by XXXXXXXXXX XXXXXXXXX, MD for low back pain. Patient states she hurt her back [redacted]go while having sexual intercourse. Assessment: Back sprain/strain. Prescribed Medrol Dosepak. Continue Flexeril, Naprosyn, and Vicodin. Recommended physical therapy. Apply heat to affected areas.

[redacted]- Seen by PA-C for left hip pain times a few years. Given today injection of Kenalog, lidocaine, and Marcaine into the *right* hip joint.

[redacted]- Seen for Mxxxx KXXXXXXX, MD for followup of left hip degenerative joint disease due to DDH. Here for

[redacted]

injection #3, administered without complication. Injection #1 helped for four months. Injection #2 did not work.

[redacted] - Given prescription for Vicodin.

[redacted] - Patient called in regarding work restrictions. She had hip injection done by Dr. MXXXXX under x-ray guidance. Describes being on her feet eight hours a day at work. Patient wants to make sure the hip injection is effective and would last long enough until January at which time she may consider surgery. If she will be placed on modified duties she would like this to be dated starting [redacted] She is currently on vacation and will return to work on [redacted]

[redacted] - Seen by MXXXX KXXXXX, MD for followup of left hip DDH status post surgery as a child; now with progressive arthrosis with severe pain. BMI [redacted]. Currently weighs [redacted] pounds. Recommended total-hip arthroplasty.

[redacted] - Seen by [redacted] KXXXXX, MD for popping in her knee with a lot of pain. Also reports popping and pain in her left hip and left thigh after injection administered on [redacted] Assessment: Left hip dysplasia with cartilage loss. The patient is placed on total temporary disability.

[redacted] - Seen at XXXXXX by [redacted] XXXXXX, MD for left hip pain. Scheduled for left hip replacement surgery with Dr. KXXXXX. Active problem list: Obesity. Abnormal Pap smear. Hip osteoarthritis. Vitamin D deficiency. Congenital hip dysplasia. Vital signs: Height is [redacted] and weighs [redacted] pounds. BMI [redacted] Assessment: Left hip osteoarthritis. The patient is placed on total temporary disability.

[redacted] - Work status report - The patient is placed on total temporary disability.

[redacted] - Given instructions regarding occupational therapy and physical therapy.

[redacted] - Progress report - Seen by GXXXXX KXXXXX, MD for left groin pain; diagnosed with left hip degenerative joint disease. Patient wishes to proceed with left total-hip arthroplasty. Assessment: Left hip dysplasia. Scheduled

[redacted]

to undergo surgery on [redacted]

[redacted] - Emergency room report - Seen at Kaiser for severe degenerative joint disease of the left hip, worse, has failed to respond to conservative treatment. Also reports left groin pain. Active problem list: Obesity. Abnormal Pap smear. Osteoarthritis of hip. Osteoarthritis. Vitamin D deficiency. Congenital hip dysplasia. Vital signs: Height is [redacted] and weighs [redacted] pounds. Assessment: Left hip dysplasia. Recommended left total-hip replacement.

[redacted] - Operative report done by [redacted] XXXXXXX, MD - Seen at [redacted]. Pre- and postoperative diagnoses: Left hip degenerative joint disease secondary to developmental dysplasia of the hip (DDH). Procedures performed: Left total-hip arthroplasty.

[redacted] - Inpatient physical therapy hip consultation report - Seen at KXXXXXX.

[redacted] - Postoperative x-rays of the left pelvis done by [redacted] XXXXXXX, MD - Seen at [redacted]. Impression: Left total-hip replacement with components in satisfactory position. Postsurgical changes seen within the surrounding soft tissues.

[redacted] - Physical therapy evaluation report - Seen at [redacted].

[redacted] - Discharge summary report - Seen at KXXXXX. Prescribed Norco, aspirin, and Colace. Continue taking ferrous sulfate and oral zinc acetate. Given instructions regarding and discharged to home.

[redacted] - Patient called in complaining of difficulties with sleep as well as anxiety since the surgery.

[redacted] - Given prescription for Valium for her anxiety.

[redacted] - Physical therapy evaluation report done by [redacted] XXXX, MSPT - Patient is status post left total-hip arthroplasty.

[redacted] - Physical therapy progress report.

[redacted] - Work status report - Wound is healing nicely. Prescribed tramadol (Ultram). The patient is placed on total temporary disability.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Seen by [redacted] KXXXXX, MD. Patient is very satisfied with the surgery. Still suffers from insomnia. Receives physical therapy. The patient is placed on total temporary disability.

[redacted] - Physical therapy progress report.

[redacted] - Seen by [redacted] KXXXXX, MD. Patient states she did 15 minutes of bicycle in the gym and two laps in the pool. The following day she felt soreness along her left lower lumbar region.

[redacted] - Postoperative progress report - Seen by [redacted] XXXXX, MD for back pain. Gives history of sciatica. States exercising increased her sciatic pain times six days; felt she had left leg paresthesias. Given instructions regarding exercises and hip precautions.

[redacted] - Physical therapy progress report.

[redacted] - Seen by [redacted] MD. Patient wants to return back to work on [redacted] inquires regarding work restrictions.

[redacted] - Physical therapy progress report.

[redacted] - Seen by PA-C. The patient is placed on total

[redacted]

partial disability; modified duties. May return to work with posterior hip precautions and perform work duties seated in a chair. Patient states her employer is giving her a hard time regarding work restrictions.

[redacted] - Work status report - The patient is placed on total partial disability; modified duties.

[redacted] - Patient called in and spoke with GXXXXX KXXXXX, MD. Patient states she returned to work as a Dental Assistant and her employer could not accommodate her work restrictions and terminated her. *Patient's posterior hip precautions must be observed at all times*: No bending of hip past 90° angle. No crossing of legs. No twisting of hip inwards. Must keep knees and toes pointed upwards. Hip is restricted from bending due to risk of dislocation. Apply ice to affected areas. Continue use of antiinflammatory.

[redacted] Surgery Group:

[redacted] - Orthopedic evaluation report - Seen by Manuel [redacted], MD. Date of injury listed as CT [redacted] Patient began to experience left hip pain at work in around [redacted] In around [redacted] she slipped-and-fell on her left side while bowling. She presented to Kaiser Permanente in [redacted] with ongoing left hip pain. Presently complains of left hip pain, increased with walking or standing. Describes the recent onset of low back pain. Complains of neck pain radiating into the shoulders. Also reports suffering from depression and anxiety. Past medical/surgical history: Underwent left hip surgery as an infant [redacted] to address developmental dysplasia of the hip (DDH). Hardware was subsequently removed at age four. Patient had a motor vehicle accident in [redacted] and received chiropractic treatment for her back. She settled her case and received Award of [redacted] In [redacted] she slipped and fell while bowling. Vital signs: Height is [redacted] and weighs [redacted] pounds. Diagnoses: Lumbar spine sprain/strain. Status post left total-hip arthroplasty with residual symptoms. Residual leg-length discrepancy, left shorter than right. Psychological sequelae secondary to industrial injury. The patient is placed on total temporary disability. Recommended x-rays of the hips bilaterally.

[redacted]

[redacted] - PR-2 - Seen by [redacted]. XXXXX, MD. Date of injury listed as CT [redacted] Seen for left hip pain and low back pain radiating down the lower extremity. Physical examination: Tenderness, decreased range of motion, decreased strength, and decreased sensation. Diagnoses: Lumbar spine sprain/strain. Status post total-hip arthroplasty. Residual leg-length discrepancy, left shorter than right. Ordered x-rays of the hip and pelvis. Referred for psych consult. The patient is placed on total temporary disability.

[redacted] - PR-2 - Seen by M. XXXXX, MD. Date of injury listed as CT [redacted] Presently complains of stiffness and pain in the left hip and lumbar spine with left lower extremity weakness. Recommended land-based physical therapy as well as aquatic therapy 2x6. The patient is placed on total temporary disability.

[redacted] - PR-2 - Seen by [redacted] XXXXX, MD. Same complaints. Same diagnoses. Residual leg-length discrepancy with left leg shorter than the right leg. Same treatment plan. Awaiting psychiatric evaluation. Still off work. Still temporarily totally disabled.

[redacted] - Progress report done by GXXXXX KXXXXX, MD - Patient is very satisfied postoperatively. Continue physical therapy, range of motion, and quadriceps strengthening.

XXXXXXXX XXXX Multi-Specialty Medical Group & Therapy:

[redacted] - Handwritten Chiropractic Doctor's first report of occupational injury or illness - Seen by *XXX XX*, DC - Body parts injured: Left hip, low back, and right wrist/hand. Date of injury listed as CT [redacted] Recommended chiropractic treatment modalities. Return to work on modified duties. No lifting, pushing, pulling over 25 pounds. No standing more than one-half hour. No walking more than 20 minutes. No repetitive bending or stooping. No squatting. Date of injury listed as CT [redacted]

[redacted] - Chiropractic evaluation report done by *JXXXX LXXX*, DC - Seen at XXX XXXXXX Multi-Specialty Medical Group & Therapy. Date of injury listed as CT [redacted]

[redacted]

Patient states she developed pain in her right wrist, low back, left hip, and right heel/foot. Also reports she developed stress, anxiety, depression, sleep difficulty, and headaches. Sustained right clavicle fracture in around [redacted] nonindustrial. Past medical history: Arthritis. Past surgical history: Left hip replacement on [redacted] industrial. Left hip surgery at age [redacted] months because her hip did not grow. Diagnoses: Posttraumatic stress disorder. Headache. Sleep difficulty. Difficulty walking. Lumbar ligament laxity. Lumbar neuritis/radiculitis. Rule out carpal tunnel syndrome, right wrist. Right hand joint effusion. Postoperative left hip total replacement. Post complication right plantar fasciitis. Insomnia. Not yet MMI. Recommended to amend patient's claim to include right hand and wrist as well as right foot/heel. Also added sleep difficulty. Recommended physiotherapy modalities as well as chiropractic care 3x8. Recommended home exercise program, work conditioning program, as well as acupuncture treatment. Recommended EMG/NCV of the bilateral lower extremities. Referred for psychological, orthopedic, Internal Medicine, as well as Pain Management consults. Return to work on modified duties. No forceful gripping with the right upper extremity. No lifting over 25 pounds. No squatting. No prolonged standing. No walking more than 20 minutes.

[redacted] - Chiropractic progress report.

There is chiropractic treatment log sheet indicating patient's regular attendance in February and [redacted]

[redacted] - MRI of the right wrist with flexion/extension done by XXXXXX KXXXXXXX, MD - Impression: Subchondral cyst of the capitate and head of the third metacarpal. Normal flexion and extension images. No other abnormalities.

[redacted] - MRI of the lumbar spine with flexion/extension done by SXXXXX KXXXXX, MD - Impression: T11-12 showed broad-based central disc protrusion encroaching the subarachnoid space. Disc measurements: 1.9 mm in neutral, extension, and flexion. L2-3 showed a broad-based central disc protrusion compressing the thecal sac and bilateral transiting nerve roots with bilateral neuroforaminal stenoses, encroaching to the bilateral exiting nerve roots. Disc measurements: 4.0 mm in neutral and 3.0 mm in

[redacted]

flexion/extension. L3-4 showed a broad-based central disc protrusion effacing the thecal sac and bilateral transiting nerve roots with left neuroforaminal stenosis, encroaching to the left exiting nerve root. Noted facet arthrosis. Disc measurements: 2.7 mm in neutral and extension; and 1.9 mm in flexion. L4-5 showed bilateral facet degeneration; facet arthrosis. L5-S1 showed diffuse disc bulge effacing the thecal sac and bilateral transiting nerve roots. Noted facet arthrosis. Disc measurements: 1.9 mm in neutral and 3.0 mm in flexion/extension. Multilevel degenerative disc disease. Disc desiccation at L2-3, L3-4, and L5-S1.

[redacted]- MRI of the left hip without and with contrast done by SXXXXX KXXXXX, MD - Impression: Several fatty and cystic changes of the superior aspect of the uterus. Clinical and historical correlation recommended. Recommended GYN referral. Right femoroacetabular arthrosis. Surgical metallic artifact overlying the left hip, consistent with previous left hip replacement surgery, limiting evaluation of the left hip. CT scan and/or x-rays of the left hip recommended. Metallic artifact extends through the pelvic brim and acetabulum which may represent medial migration of the surgical hardware however x-ray study or CT scan of the left hip is suggested. No contrast enhancement seen. No other abnormalities.

[redacted]- Physical therapy progress report.

[redacted] - Anatomical impairment measurements (AiM) report done by SXXX KXXXX, MD - Body parts injured: *Right wrist.*

[redacted] - Anatomical impairment measurements (AiM) report done by SXXXX KXXXX, MD - Body parts injured: *Left hip.*

[redacted] - Anatomical impairment measurements (AiM) report done by Sana Khan, MD - Body parts injured: *Lumbar spine.*

[redacted] - Psychological evaluation report done by AXXXX DXXX, PhD - *Seen and examined actually on* [redacted] Date of injury listed as CT [redacted] Diagnostic impression: Axis 1: Adjustment disorder, not otherwise specified. Primary insomnia. Axis 2: Deferred. Axis 3: Deferred to appropriate examining physicians. Axis 4: Occupational, economic, as well as problems related to

[redacted]

interaction with the legal system. Axis 5: Current GAF score is 66; *corresponding whole person impairment is 6%*. Recommended psychotherapy as well as cognitive-behavioral therapy.

[redacted] - Physical therapy progress report.

[redacted] - Chiropractic PR-2 - Seen by XXX XXX, DC. Same complaints. Same diagnoses: Rule out cubital tunnel syndrome. Rule out carpal tunnel syndrome. Gait abnormality. Myofascitis. Status post left hip replacement, stable. Stress. Headaches. Insomnia. Pain in the lumbar spine, right wrist, right ankle, and right foot. Lumbar spine disc syndrome/radiculitis. Right plantar fasciitis. Same treatment plan. Continue acupuncture and physical therapy 3x6. Still on modified duties. Same work restrictions. Recommended ThermoCool compression system at 30 minutes per day time 60 days; DME trial; ESWT for the right foot; as well as EMG/NCV of the bilateral lower extremities. Follow up with Pain Management and Psychology. Referred for FCE evaluation.

[redacted] - Autonomic nervous system function testing report with interpretation - Seen by XXXXX XXXXX, MD. Referred by XXX XXXXX, DC.

There is chiropractic treatment as well as physical therapy log sheet indicating patient's regular attendance in March and [redacted]

[redacted] - Psychotherapy progress report done by SXXXXXX XXXXXX, PsyD.

[redacted] - Computerized range of motion and muscle strength study performed by [redacted] DC. Referred by [redacted] DC.

EXXXXXXXX XXXXXXXXX, MD:

[redacted] - Pain Management evaluation report - Seen at XXXXXXX XXXXXX Stop Multi-Specialty Medical Group & Therapy by XXXXXXX XXXXXXX, MD. Referred by XXXXXXXX XXXXX, DC. Present complaints: Right foot pain; left thigh pain; left buttock pain; and low back pain. *Low back pain started in*

[redacted]

the early [redacted] intermittently; attributed to prolonged standing, walking, and sitting at work; did not report her injury to her employer. *Right wrist pain started in around* [redacted] attributed to repetitive grasping, pushing/pulling, and carrying charts and supply boxes at work weighing around 25 pounds; did not report her injury to her employer; went to Kaiser and diagnosed with tendinitis. *She continued working from* [redacted] *with persistent pain in her right wrist and low back*. In around [redacted] she began to experience stress, anxiety, depression, and headaches; attributed to change of ownership of the practice she worked for; did not report her symptoms and continued working. Past medical history: Arthritis. Takes Naprosyn. Medical records were reviewed. Diagnostic impression: Axial low back pain. Lumbar facet arthropathy. Status post left hip replacement. Right foot tenosynovitis. Given today injection of Kenalog and lidocaine into the right foot with relief of discomfort. Recommended lumbar diagnostic facet block due to very little discopathy. Prescribed Naprosyn, tizanidine (Zanaflex), Ultracet, as well as topical creams. Work status per primary treating physician.

[redacted] - Chiropractic Supplemental report done by Phu La, DC - Medical records were reviewed.

[redacted] - Extracorporeal shockwave therapy report done by MXXXXXXX XXXXXX, DO - Procedure #1. Diagnoses: Right wrist/hand tenosynovitis/tendonopathy. Patient received 1000 shocks at the initial level 5 at a force of 1.1.

[redacted] - Psychotherapy progress report done by SXXXXXX XXXX, PsyD.

[redacted] - Internal Medicine evaluation report - Seen at XXX XXXXXX Multi-Specialty Medical Group & Therapy by Michael RXXXX XXX, MD for insomnia and headaches. Referred by XXX XX , DC. Impression: Insomnia. Headache. Prescribed topiramate (Topamax).

[redacted] Chiropractic Supplemental report done by PXXX XXX, DC - Medical records were reviewed.

[redacted] - Handwritten Chiropractic PR-2 - Seen by PXXX XXX me complaints. Same diagnoses. Same treatment plan. Still

[redacted]

on modified duties. Same work restrictions. No lifting over 25 pounds. No carrying over 20 pounds. Limited standing to no more than one-and-a-half hours. No repetitive bending, stooping, power gripping/grasping, or squatting.

[redacted] - Psychotherapy progress report done by SXXXXX XXXXXX, MD

There is chiropractic treatment as well as physical therapy log sheet indicating patient's regular attendance in [redacted]

[redacted] - Handwritten Chiropractic PR-2 - Seen by XXX XX, DC. Same complaints. Same diagnoses. Same treatment plan, added Biofreeze. Still on modified duties. Same work restrictions.

[redacted] - EMG/NCV of the bilateral upper extremities done by XXXXX XX, MD - Impression: Normal EMG. Abnormal NCV with findings suggestive of right carpal tunnel syndrome. Follow up with XXX XX, DC.

[redacted] - Physical therapy progress report.

There is chiropractic treatment log sheet indicating patient's regular attendance in [redacted].

[redacted] - Handwritten Chiropractic PR-2 - Seen by XXX XXX, DC. Same complaints. Same diagnoses. Same treatment plan. Still on modified duties. Same work restrictions.

[redacted] - Chiropractic progress report.

[redacted] - Internal Medicine progress report done by [redacted], MD - Continue topiramate (Topamax). Prescribed Ambien.

[redacted] - Chiropractic Supplemental report done by XXXXXX XXXXX, DC - Medical records were reviewed.

[redacted] - Chiropractic progress report.

There is chiropractic treatment log sheet indicating

[redacted]

patient's regular attendance in September and [redacted]

DEPOSITION OF XXXXXXXX [redacted], VOLUME 1:

[redacted] - Pages 1 through 71 - The patient had an auto accident in the [redacted] wherein she was a driver and he sustained injury to her low back. She eventually settled his case; does not remember how much he received. Denies any residuals. Goes through her family and living situation as well as her educational attainment. Started working for Dr. XXXX in [redacted]. Explains that she actually started working for Dr. [redacted] in [redacted] and then Dr. [redacted] owned the practice in [redacted] He job duties included ordering; doing chair side, charts, front office, OSHA, setting and breaking up rooms, sterilization, x-rays, four- to six-handed dentistry, impressions, fixing things, *waterlase*, air abrasion, corner polishing, bleaching teeth, treatment plans, treatment conferences, temporary crowns, checking insurance, banking, computers, as well as scheduling and confirming appointments. She was placed off work from [redacted] through [redacted]. Underwent left total-hip replacement at XXXXXXX XXXXXX [redacted] She last worked on [redacted]; states *she was fired*. Explains that Dr. DXXXX just showed her a list of patients (all of whom were personal friends of his) who had complaints against her. Dr. DXXXXX told her he had many patient complaints and fired her. *Patient testifies she would have continued working had she not been fired.* Had concurrent employment while working for Dr. DXXXX. Goes through her prior employment (prior to Dr. DXXXX). There was discussion about her Workers' Compensation claim in [redacted] against XXXX [redacted] Corporation; described she was held up at gun point. She received counseling for about six months. She obtained an attorney and eventually received a Settlement. Patient described working at XXXXXXX Dental Care as a Registered Dental Assistant (subsequent to her employment with Dr. DXXXX) but she had to stop because she was being asked to do tasks which exceeded her work restrictions as a result of her hip surgery which included no lifting over 10 pounds; no standing pigeon-toed; no crossing of legs; no bending more than 90°. Patient is currently not working; states she is looking for work as a Dental Assistant; *had sent out* [redacted] *resumes* to dental offices. Patient explains that she actually had been hired

[redacted]

by [redacted] and scheduled to start working on the [redacted]th ([redacted] doing vacation planning as well as ticket selling. Gives history of fractured right clavicle at around age [redacted] while riding a skateboard, received treatment at WXXXX XXXXX Hospital, no residuals. There was discussion about her left hip surgery at age [redacted] secondary to a birth defect. She had an emergency room visit in [redacted] due to work-related stress; described Dr. [redacted] was taking her duties away from her when he overtook the practice; also cut her work hours. States Dr. [redacted] put his sister as the Head Assistant. She was working on charts more and cleaning rooms. At one time she had to go to the emergency department due to work-related anxiety and stress. She did not get back her old duties. There was discussion about her present Workers' Compensation claim: Body parts injured include her left hip and sciatic nerve status post hip replacement; right wrist tendonitis (on Naprosyn); and right foot on a compensatory basis (wears Velcro brace). Patient underwent left hip surgery as an infant and followed by hardware removal at [redacted] She is not sure when her left leg became shorter than her right leg. She noticing problems with her left hip since she fell in [redacted] while bowling. She landed on her buttocks. She went to Kaiser for medical treatment and was referred to Dr. [redacted]. In [redacted] Dr. [redacted] told her arthritis had set in and hip replacement is needed. Dr. KXXXXXX (Kaiser) gave her an injection on [redacted] which helped. She received a total of four injections (including one injection into her left thigh in [redacted] which did not work). She finally underwent surgery on [redacted] Denies any sciatic symptoms prior to her surgery. Patient testifies that *prior to her bowling/falling incident she was on her feet at work eight hours a day and was not having pain.* Patient states that at the present time she does not have any pain in her hip or sciatic nerve, zero pain level. There was discussion about her psychiatric symptoms including anxiety and depression. Upon further questioning, the patient describes she is presently having intermittent pain in her low back, left hip, and left leg. Her low back pain was worst in [redacted] (postoperative). She is also having problems with her right foot. She still has tendonitis in her right wrist. Her hip pain increased in the last year she was working for Dr. [redacted] and her right wrist pain worsened, attributed to work activities.

[redacted]

Also describes her left leg pain worsened in the past year. She is able to do her activities of daily living including personal hygiene. She is seeing Dr. [redacted] XX tomorrow. Dr. [redacted] told her left leg is shorter than her right leg. She still experiences weakness on her left side. She performs her home exercises.

DEPOSITION OF BXXXXXX [redacted], VOLUME 2:

[redacted] - Pages 72 through 148 - The patient takes naproxen and a pill to help her sleep. Goes through her family and living situation. She started working at XXXXXX on [redacted]. Her job duties include vacation planning and selling tickets in the ticket booth. Her job there entails sitting. She works around 20 hours per week. Has difficulty doing her job because of her wrist and right foot. Has constant right foot pain. Describes working at a computer her whole work shift. She is also currently working part-time at a dental office (Dr. [redacted]). She started working there on [redacted] as a Dental Assistant, works around [redacted] hours per week. Her job duties include assisting the doctor, doing chair side, performing x-rays, pouring up models, sterilizing instruments, computer work, as well as talking to patients. Has difficulty doing her job because of her wrist, hand, and foot, also her back. Has pins & needles in her right hand as well as stiffness in her right index finger. She wears her wrist brace but not at work. She experiences needles in her right foot especially when standing up. She wears her boot when she sleeps. She works at the dental office on [redacted] and [redacted] She works at XXXXXX on [redacted], [redacted] Describes she has an assistant at the dental office who does the cleaning. Her current work restrictions include no bending; no standing over half an hour; no stooping; no lifting over 25 pounds; no carrying over 20 pounds; no power gripping; no squatting, or stooping. She informed the doctor about her restrictions when she started working and *they are being honored*. Her hip pain began in around [redacted] following a bowling incident. Right after that she began experiencing pain in her right foot because she was compensating all her weight onto her right foot; explains she would take her left foot and put it on top of her right foot and bear all her weight on her right foot. A podiatrist at XXXXX gave her a boot as well

[redacted]

as insoles for her shoes. Dr. XXX gave her a cortisone injection to her foot a few months ago which helped temporarily. Relates she was performing her exercises at one time and her *sciatic* went out placing her back to using the cane. She feels stabbing pain in her right foot when she stands up, flexes her right foot, or lies down. Has discomfort in her hip. Patient states that after her surgery, she returned back to work only after *two and a half days* (sic). At one time she was asked to work on a machine (air abrasion) which was beyond her restrictions. She went home with pain in her hip and back. She was afraid to tell or remind her employer about her restrictions due to fear of losing her job; her employer ended up firing her two days later anyway. Dr. XXX stopped the acupuncture treatment to her left hip, low back, right foot, and right hand because it was not helping. Shock wave treatment was done once. She currently has problems walking with her right foot and limps with her left leg. There was discussion about her psychiatric symptoms: Patient relates she was previously working for Dr. [redacted] as the Head Assistant and then Dr. [redacted] took over the practice and took away her job duties and gave it to his sister which caused her a lot of stress. Dr. [redacted] did not change the job duties of the other employees. He made her sister the Head Assistant. Patient relates experiencing harassment from the front desk (XXXX). She is still on her 90-day probation with Dr. [redacted] Dr. [redacted] referred her to Dr. LXXXXXXXXX for employment. Dr. [redacted] took over the practice in [redacted] and in around [redacted] her boyfriend rushed her to the XXXXXX emergency room secondary to anxiety and stress. Her EKG was normal. No therapy or biofeedback was requested. She could not recall if she was given any medication. Patient described receiving harassing text messages from XXXX. MXXX could be nice one day and a snake another day. One text message she received from MXXXX stated, ''*If you're not resting, I'm going to come and kidnap you and kill you.*'' Patient took it as a joking matter. There was further discussion about her work relationship with [redacted] especially regarding her Disability, surgery schedule, the surgery itself, as well as her postoperative course. Patient mentions filing a wrongful termination claim against Dr. XXXXX which had been restricted and settled. Patient states [redacted] was the Office Manager and has the power to hire or fire anybody and that was why she was fired.

[redacted]

This concludes the review of available records.

PHYSICAL EXAMINATION:

GENERAL:

The patient is a well-developed, well-nourished, 50-year-old, right-handed female in no acute distress. She appears her stated height of 5'XX tall and weight of XXX pounds.

GAIT/STANCE:

The patient ambulates independently with a normal heel-toe gait without the aid of any assistive devices.

In the examining room, the patient stands straight with the spine erect. The pelvis and shoulders are level to the floor.

RIGHT WRIST:

There is no deformity, heat, swelling or erythema. There is mild tenderness to palpation. The radial and ulnar joints are nontender.

There is full range of motion of the wrists.

Tinel's sign is questionable positive on the right, Phalen's test, and Finkelstein's tests are negative bilaterally.

UPPER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Forearms (Largest circumference):	26 cm	26 cm
Arms (Mid biceps):	34 cm	34 cm

LUMBAR SPINE:

There is a normal lumbar lordotic curvature. There is no

[redacted]

paralumbar spasm. There is no paralumbar tenderness. There is mild tenderness in the midline. There is mild left SI joint tenderness.

She is able to stand on her heels and toes without difficulty.

After adequate warm-up, the patient is able to forward flex the lumbosacral spine so that the tips of her fingers reach the knees and arise to the erect position without difficulty.

HIPS:

There is full and painless range of motion of the right hip.

The left hip has a well healed surgical scar that is nontender with no sign of infection. It is not adherent to underlying tissue.

The patient can flex her left hip to 80 degrees and extend it to 0 degrees. There if full abduction, adduction, there is limitation in internal to 10 degrees and external rotation to 20 degrees.

The greater trochanters are nontender bilaterally.

LOWER EXTREMITIES:

Reflexes: Knees 2+ and symmetrical; ankles 2+ and symmetrical.

There is no ankle clonus.

There is a negative Babinski sign.

There is no motor deficit of either lower extremity as evidenced by a strong tibialis anterior, extensor hallucis longus, quadriceps femoris and gastrocnemius muscles.

There is no sensory deficit to the Wartenberg pinwheel.

There is no vascular deficit.

[redacted]

Peripheral pulses are full and intact.

LOWER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Calves (at the widest point):	25 cm	25 cm
Thighs (10 cm above the superior pole of the patella):	56 cm	56 cm
Leg Lengths	91 cm	89.5 cm

RIGHT FOOT:

There is no deformity and full range of motion. There is no tenderness noted at this time. She says his is a good day.

DIAGNOSIS:

1. Left hip degenerative joint disease secondary to acetabular dysplasia as a child aggravated and exacerbated by a slip and fall accident at the bowling alley, status post total hip replacement.

2. Lumbosacral sprain/strain.

3. History of mild inflammation of the right foot, non-industrial in nature.

4. Tendinitis of the right hand, resolved.

DISCUSSION:

After reviewing the records supplied to me, taking a history of the patient, as well as doing the examination, it is my opinion that this patient did not sustain any industrial injury her left hip. The problems with the hip are due to the acetabular dysplasia as a child, resulting in the need surgery and resulting in pin removal. The hip arthritis that she developed was a normal progression with the acetabular dysplasia that she had as a child and is a common

[redacted]

consequence. That dysplasia was aggravated by a non-industrial slip and fall in the bowling alley. In my opinion, it is not due to any employment while working for Dr. [redacted] as that job did not involve standing all day and the patient could sit at times during the day. I feel that her work played no role at all in her left problem, disability and need for treatment.

The patient during her history to me seems very bitter towards Dr. [redacted] due to her termination, but that does not mean she had any significant continuous trauma injury to the hip while working for him. She spent a great deal of time today complaining of stress and problems with obtaining jobs and references.

It should be noted that while she is now claiming a continuous trauma injury working for Dr. [redacted] she made no such claim at the time of her hip surgery and all of that surgery was done on a non-industrial basis.

With regard to the hip she has done fairly well since the surgery. She clearly is at MMI status.

She also reports lumbar spine pain. There was some indication in the records of so low back complaints. I feel the low back pain is a combination of leaning over assisting the dentist in his office and the result of altered gait from her total hip procedure. There is no sign of lumbar disc disease and no lower extremity radiculopathy. She is also at MMI status in this regard.

She also complaints of right foot pain, which she actually relates to the hip in that she would stand more on the right to take pressure of the left hip. Today, I really see nothing that needs treatment for the right foot and I cannot see how this could be related to her job with Dr. [redacted] In fact she admits this did not even begin until [redacted]

Her other complaint is a history of right wrist pain for many years. She feels this is due to her work and the repeated use of her right hand and wrist as a dental assistance. It appears this began during the time she worked for Dr. [redacted] and it is reasonable she could have some tendonitis, but this is also considered to be at MMI

[redacted]

status.

AMA IMPAIRMENT:

The patient is rated using the AMA Guides, 5th Edition:

For the left hip, she is rated using Pages 546 and 548. Using Table 17-34 for a hip replacement, she had a fair result, with 79 points. Using Table 17-33 this is a 20% whole person impairment.

For the lumbar spine, using Table 15-3 she is a DRE Category II, with some decreased range of motion and radicular complaints, but no true radiculopathy. She has a 7% whole person impairment.

For the right wrist, I would take this into consideration with her ADLs and pain and provide her with a 2% whole person impairment.

There is no impairment for the right foot.

Her total whole person impairment combined is 27%.

WORK PRECLUSIONS:

For the left hip she is precluded from prolonged standing or walking, very limited climbing, and no lifting, pushing or pulling more than 20 pounds.

The same restrictions would be in place for the lumbar spine.

For the right wrist, she should wear the wrist brace, and must take a break after 30 minutes of use of her hands.

FUTURE MEDICAL CARE:

None for the left hip on an industrial basis.

For the lumbar spine, she should be allowed follow-up visits, use of non-steroidal anti-inflammatories, non-narcotic pain medications, such as Ultram, and short courses of therapy or acupuncture, not to exceed two courses a year.

[redacted]

For the right wrist, the use of a right wrist brace, the use of anti-inflammatories is all that is required.

CAUSATION & APPORTIONMENT:

I addressed causation earlier in my discussion. The left hip was in no way caused or aggravated by her work. This problem began as a child and progressed to the point she needed surgery. There was some aggravation due to the bowling alley incident, not her work. 100% of her left hip disability is due to the non-industrial factors.

The low back pain is due to a combination of assisting at Dr. [redacted] and office and the result of altered gait from her total hip procedure. I would apportion 60% to the hip surgery and the remaining 40% to her work at Dr. [redacted] office on a cumulative trauma basis.

The right foot is unrelated to her work at Dr. DXXXX.

The right wrist is secondary to overuse on her job. I would apportion this 100% to the cumulative trauma.

DISCLOSURE:

This patient was interviewed and examined by the undersigned; the medical records were reviewed; and this dictation was done solely by the undersigned.

The attached statement for billing for the services of this evaluation and report are true and correct to the best of my knowledge.

There has not been a violation of Sec. 139.3 in conjunction with this evaluation to the best of my knowledge.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein,

[redacted]

that I believe it to be true.

Sincerely,

KENNETH P. SCHEFFELS, M.D.
Diplomate, American Board of
Orthopedic Surgery

Signed in Los Angeles County on _____

KPS/fm/mte

cc: TXXXXXXX
XXXXXXXX [redacted]
Attn: [redacted]
P.O. Box XXXX
WXXXXX XXXXX, California XXXXX

LAW OFFICES [redacted] XXXXXXXX (REPRESENTING THE [redacted]
Attn: [redacted] HXXXXXX, Esquire
P.O. Box XXXX
XXXXX, California XXXXX

SAMPLE.

KENNETH P. SCHEFFELS, M.D.

Diplomate, American Board of Orthopedic Surgery

4940 Van Nuys Boulevard, Suite 302
Sherman Oaks, California 91403
(818) 990-4497

#2

[redacted]

[redacted]

Attention: xxxxx xxxxxx, Claims Representative

CLAIMANT : [redacted]
CLAIM NO :
REQUESTOR: XXXXXXXX XXXXX
COVENTRY#: [redacted]
COVERAGE : DEFENSE BASE ACT
ACCT. NO : XXXX
D/INJURY : [redacted]
D/EXAMIN :

ORTHOPEDIC IME EVALUATION REPORT

Dear Ms. XXX:

Today, I had the opportunity to perform an orthopedic IME evaluation in my Sherman Oaks office on Ms. [redacted] a 59-year-old, right-handed female. Ms. XXXX gives me the following history.

She is seen today with regard to her claim of shoulders, upper arm, neck and head.

EMPLOYMENT AT TIME OF INCIDENT:

Ms. [redacted] worked as a flight attendant for XXXXXXXX [redacted] She worked for this employer for [redacted] She worked about 80 hours per month. She performed standard flight attendant duties, but reports at the end o[redacted]er job involved working more in the galley, cooking meals in an overhead oven and serving food. This required repeated overhead reaching with both upper extremities. She

[redacted]

denies concurrent employment. She last worked in [redacted].

HISTORY OF THE PRESENT INJURY:

Ms. [redacted] states that during the course of her employment she performed repeated overhead reaching with both upper extremities, right side more than left. As a result, she developed pain and limitation of motion in both shoulders. This began in about [redacted], and progressively worsened until she obtained medical care under her private insurance in [redacted] She was then taken off work.

She saw Dr. [redacted] three times, and was then referred to a rheumatologist for blood tests. She was found to be ANA positive. She also had MRI's of both shoulders, but is not clear about the results. She was seen by a rheumatologist Dr.XXXX.

Due to continued shoulder pains, she eventually went to Human Resources and officially filed a workers' compensation claim.

Due to continued shoulder pain, she saw an orthopedist, Dr. [redacted] XXXXX and due to the positive MRIs, she underwent right shoulder arthroscopy on [redacted] and left shoulder arthroscopy on [redacted]

She had extensive post-operative physical therapy on the right shoulder and is currently doing home exercises for her right shoulder. She continues to receive physical therapy, two times per week, for her left shoulder.

CURRENT ORTHOPEDIC COMPLAINTS:

1. Left shoulder pain and stiffness, worse with motion, especially overhead reaching. She states she has a "frozen shoulder".

2. Right shoulder stiffness and pain exacerbated by overhead reaching and motion.

She does not describe any neck pain either on her questionnaire or verbally to me today.

CURRENT JOB STATUS:

Ms. [redacted] is not working. She is collecting workers' compensation disability.

[redacted]

She last worked in [redacted], but is unclear on the date.

PAST MEDICAL HISTORY:

WORK INJURIES:

None prior.

ILLNESSES:

The patient denies any history of tuberculosis, pneumonia, or asthma. There is no history of heart disease, hypertension, diabetes, epilepsy, liver disease, kidney disease, thyroid disease, ulcers, or cancer.

ALLERGIES:

Denied.

SURGERIES:

[redacted] breast reduction; [redacted] right shoulder arthroscopy; [redacted] eft shoulder arthroscopy.

AUTO ACCIDENTS:

[redacted] no injuries.

FAMILY HISTORY:

Mother and grandmother had cancer. Father had diabetes.

SOCIAL HISTORY:

The patient denies the use of tobacco or alcohol. She does not use illicit drugs.

REVIEW OF MEDICAL RECORDS:

Ms. [redacted] completed an ADL form today and this was reviewed.

[redacted] – Cover letter from [redacted] reviewed.

[redacted]

[redacted] XXXXX& [redacted] XXXXXXX [redacted]

[redacted], MD:

[redacted] Work status report - Seen for sudden onset of low back pain. Off work for two weeks. Return to work on [redacted]

[redacted] - Work status report - Seen for sudden onset of low back pain. The patient is placed on total temporary disability. Off work until [redacted]

[redacted] Work status report – *Seen at XXXXXX XXXXX Medical Center* by [redacted] XXXX, MD secondary to ongoing back symptoms. Patient is unable to perform her job duties. The patient is placed on total temporary disability times six weeks.

[redacted] Work status report – Still temporarily totally disabled. Receives physical therapy. Off work until [redacted]

[redacted] X-rays of the right shoulder and humerus done by [redacted] XXXX, MD – *Impression*: Unremarkable x-rays of the right shoulder and right humerus. No fracture. Intact articular surfaces.

[redacted] – X-rays of the left shoulder and humerus done by [redacted] XXXX, MD – *Impression*: Unremarkable x-rays of the left shoulder and left humerus. No fracture. Intact articular surfaces.

[redacted] Seen by [redacted] MD at XXXX XXXX Health Center for bilateral arm pain radiating from deltoid muscles. Patient works as a Flight Attendant. Describes doing lifting at work. Physical examination: Bilateral upper extremities nontender with full ranges of motion. Assessment: Bilateral arm pain. URI symptoms. Fatigue. Ordered x-rays as well as various laboratory tests.

[redacted] – Seen by [redacted], MD. Laboratory tests came back with positive ANA (1:80). Assessment: Myalgia. Referred for Rheumatology consult. Follow up with Dr. XXXXX. FMLA forms filled out for two months' leave.

[redacted] – Seen by [redacted] XXXXXX, MD for followup of migraines, osteoporosis (lumbar spine), and low vitamin D. Current medications: alprazolam (Xanax), oxycodone-acetaminophen, and eletriptan (Relpax). Same complaints of significant bilateral arm pain, attributed to her work activities. States her surgeon believes her positive ANA is partly due to her silicone breast implants which were already removed. Presents tearful when discussing her pains. Diagnoses: Bilateral

[redacted]

shoulder joint pains. Bilateral arm pain. Osteoporosis. Low vitamin D, lumbar spine. Migraine. Referred for Workers' Compensation evaluation. Prescribed Advil. Recommended MRIs of the cervical spine and bilateral shoulders. Continue physical therapy. Injections to biceps tendon offered but patient declined.

[redacted] – MRI of the right shoulder done by XXXXXXX XXXXXXX, MD – *Findings*: Focal area of low signal on T1 and T2 weighted images within the supraspinatus tendon measuring 8.0 mm in diameter, consistent with calcific tendinosis of the supraspinatus tendon. Mild right acromioclavicular joint degenerative changes. Mild degenerative changes of right greater tuberosity. There is a tear of the right superior labrum anteriorly with tendinosis versus partial tear of attachment of the tendon of long head of biceps. Noted thickening and edema of right superior glenohumeral ligament and joint capsule and to a lesser extent the inferior joint capsule (either result of prior trauma or adhesive capsulitis). Clinical correlation advised. Small joint effusion seen. *Impression*: Edema of the superior glenohumeral ligament and the joint capsule and also inferior joint capsule which can be seen as a result of prior trauma or adhesive capsulitis. Calcific tendinosis of the supraspinatus tendon. Tear of the superior labrum anteriorly and tendinosis of the attachment of the tendon for long head of biceps. Joint effusion. Mild acromioclavicular joint degenerative changes with no evidence of impingement.

[redacted] – Orthopedic evaluation report – Seen by XXXXXXX XXXXX, MD at XXXX XXXXXX [redacted]. Job title: Flight Attendant. Work activities include repetitive reaching, lifting, and overhead activities which caused constant chronic bilateral shoulder pain and neck pain. Past surgical history: Bilateral breast reconstruction surgeries. Current medications: *Valacyclovir (Valtrex)*, eletriptan (Relpax), Xanax, and Advil. Noted the MRI findings of the cervical spine and shoulders. Assessment: Cervical stenoses. Bilateral acromioclavicular joint arthroses, impingement syndrome. Right shoulder calcific tendinitis and labral tear. Causation: Industrial. Recommended right subacromial decompression, right acromioclavicular joint arthroplasty, removal of calcium deposit, rotator cuff repair, and superior labral treatment.

[redacted] – Operative report done by XXXXXXXX XXXXX, MD – Pre- and postoperative diagnoses: Right shoulder rotator cuff tear, calcific tendonitis, acromioclavicular joint arthrosis, impingement syndrome, synovitis, and adhesive capsulitis. *Procedures performed*: Right shoulder arthroscopic repair of rotator cuff tendon tear. Arthroscopic right acromioclavicular joint arthroplasty, extensive debridement, lysis of adhesions, and subacromial decompression. *Findings*: Right glenohumeral space showed significant synovitis in the anterior and posterior compartments with minimal articular changes to the right humeral head or glenoid.

[redacted]

Noted adhesions across the anterior and posterior aspect of the shoulder. Some fraying of the right superior labrum. 90% partial-thickness undersurface tear of the anterior attachment site of the right supraspinatus tendon. Right subacromial space showed extensive bursitis in the subacromial space. Release of the right coracoacromial ligament exposed a 7.0 mm anterolateral subacromial bone spur.

[redacted] – Postoperative physical therapy evaluation report done by XXXXX XXXXX PT.

[redacted] Physical therapy progress report.

[redacted] – Letter from XXXXX XXXXXX, MD indicating patient was on FMLA leave from work since her job duties were felt to be exacerbating her symptoms.

Further physical therapy progress reports from XXXX XXXXXXX, PT dated [redacted]

[redacted] Acupuncture evaluation report done by [redacted]

[redacted] – Acupuncture progress report done by [redacted]

[redacted] Acupuncture progress report done by [redacted]

[redacted] Physical therapy progress report done by [redacted] PT.

[redacted] – Acupuncture progress report done by [redacted]

Further physical therapy progress reports from [redacted] *PT dated* [redacted]

[redacted] – MRI of the left shoulder done by JXXXX XXXXX, MD – Referred by [redacted] XXXXXXX, MD. *Findings*: Minor degenerative changes in the left acromioclavicular joint with tiny bursal effusion. Type 2 acromion. Tiny zones of undersurface tearing. Focus of presumed calcification in the left supraspinatus near its insertion; recommended correlation with conventional film. *Impression*: Minor insertional tearing of the footprint of the left supraspinatus. There may be a focus of calcification in the distal supraspinatus tendon. Correlation radiography is recommended.

[redacted]

[redacted] – Physical therapy progress report done by [redacted] XXXXXX, PT.

[redacted] – Physical therapy progress report done by [redacted] XXXXXX, PT.

[redacted] – Operative report done by [redacted] XXXXXX, MD – Pre- and postoperative diagnoses: Left shoulder impingement syndrome, acromioclavicular joint arthrosis, synovitis, and adhesive capsulitis. *Procedures performed*: Left shoulder arthroscopic acromioclavicular joint arthroplasty. Arthroscopic extensive debridement, lysis of adhesions, and subacromial decompression. *Findings*: Fraying of the anterior labrum with some synovitis in the left glenohumeral joint space. Left subacromial space showed extensive bursitis and adhesions throughout the subacromial space. Release of the left coracoacromial ligament exposed a 6.0 mm anterolateral subacromial bone spur. Left acromioclavicular joint showed extruded disc with stenotic acromioclavicular joint.

[redacted] – Postoperative physical therapy evaluation report done by [redacted], PT.

Further physical therapy progress reports from EXXX XXXXXXa, PT dated [redacted], and [redacted]

[redacted] – MRI of the left shoulder done by [redacted] XXXX, MD – Referred by [redacted] XXXXXX, MD – *Findings*: Surgical changes including resection of the left acromioclavicular joint and the undersurface of the left acromion. Noted fluid present in the operative bed; small amount of fluid seen in the bursa. Mild signal changes in the left rotator cuff consistent with tendinosis but no rotator cuff tear. Mild changes including left subscapularis tendinosis. *Impression*: Since the prior study of [redacted] the patient has had surgery at the left acromion and left acromioclavicular joint. No evidence of rotator cuff tear. Since the prior exam, mild changes of subscapularis tendinosis have appeared.

Further physical therapy progress reports from EXXXX OXXXXX, PT dated [redacted] and [redacted]

UNDATED letter from the patient indicating she suffers from extreme pain in her shoulders, upper arms, and neck. Three doctors she had seen all agreed her pain is caused by her work activities including reaching and bending. She cannot bend her arms behind to hook her bra or put a shirt over her head. Lying down on either side is painful. She feels weak in her arms and hands. She started working the galley in

[redacted]

[redacted] *having the carts, supplies, and meals ready; and filling the bins when there were extra supplies. In* [redacted] *she worked most of her off days and worked in the galleys a lot. Described taking in and out and moving heavy oven racks several times to cook the meals evenly. Described doing a lot of reaching and stretching when getting bins for sodas, water, and other supplies. Her bilateral arm pain progressed in around early* [redacted] *She continued working; rested as much as possible in between flights. Reiterates she worked straight from* [redacted] *through* [redacted] *without days off right into* [redacted] *She constantly reported her bilateral arm pains to her Supervisors and coworkers. She last worked on* [redacted] *States she was in so much pain, fatigue, and distress that she started crying in the doctor's office.*

This concludes the review of medical records.

PHYSICAL EXAMINATION:

GENERAL:

The patient is a well-developed, well-nourished, 59-year-old, right-handed female who appears younger than her stated age. Her stated height is [redacted] stated weight [redacted] pounds.

GAIT/STANCE:

The patient ambulates independently with a normal heel-toe gait without the aid of any assistive devices.

In the examining room, the patient stands straight with the spine erect. The pelvis and shoulders are level to the floor.

CERVICAL SPINE:

There is full and painless active and passive range of motion of the cervical spine in all planes. There is no paracervical spasm. There is no paracervical tenderness. There is no tenderness in the midline. There is no trapezius tenderness or spasm.

UPPER EXTREMITIES:

Biceps and triceps reflexes are 2+ and symmetrical.

[redacted]

There is no motor deficit of either upper extremity.

The patient is able to oppose the tips of her thumbs to the heads of the fifth metacarpals.

She is able to flex all fingers so that they reach the mid-palmar crease.

The patient is able to oppose the tips of her thumbs to the tips of all of her digits.

She has full abduction and adduction of all of her digits.

There is no intrinsic atrophy.

There is no hypothenar or thenar atrophy.

There is no sensory deficit to the Wartenberg pinwheel.

There is no vascular deficit.

Peripheral pulses are full and intact. There is good capillary filling of all digits.

SHOULDERS:

There are well-healed arthroscopic portal scars about both shoulders. The scars are nontender and not adherent to underlying tissue. There is no keloid formation or sign of infection.

Examination of the right shoulder reveals abduction to 90 degrees and flexion to 140 degrees. Remaining motions are full. There is only mild pain with abduction and flexion. There is no strength deficit.

Examination of the left shoulder reveals abduction to 80 degrees and flexion to 130 degrees. There is significant pain with attempt to do range of motion of the left shoulder.

There is no point tenderness at the biceps grooves, subacromial bursae, or AC joints bilaterally.

Impingement sign is negative bilaterally.

[redacted]

ELBOWS:

Examination of the elbows reveals full, painless range of motion; 0 degrees extension, 140 degrees flexion, 90 degrees pronation, and 90 degrees supination.

There is no tenderness at the medial or lateral epicondyles.

There is a negative Tinel's sign at the cubital tunnels.

WRISTS/HANDS:

The radioulnar joints are nontender.

There is full range of motion of the wrists.

Tinel's sign, Phalen's test, and Finkelstein's test are negative bilaterally.

UPPER EXTREMITY MEASUREMENTS:

		RIGHT	LEFT
Forearms (Largest circumference)	:	24 cm	24 cm
Arms (Mid biceps):		29 cm	29 cm

DIAGNOSES:

1. Continuous trauma/repetitive trauma injury, bilateral shoulders, secondary to work as a flight attendant; status post arthroscopy bilateral shoulders, right shoulder AC joint arthroplasty and rotator cuff repair [redacted] left shoulder debridement and subacromial decompression on [redacted]

2. History of prior neck pain in records, no industrial injury to the cervical spine.

DISCUSSION:

At this time, it is within reasonable medical probability that this patient sustained a continuous trauma injury to both shoulders as a result of her work as a flight attendant. She describes the overhead activities and use of the arms that would be

[redacted]

consistent with the development of symptoms due to her job. This has resulted in internal derangement bilaterally with the need for shoulder arthroscopies.

She had right shoulder surgery on [redacted] and has completed all postoperative therapy. I believe she has reached maximum medical improvement for the right shoulder.

The left shoulder surgery was performed on [redacted] and she remains in the rehabilitation phase for the left shoulder. I anticipate an MMI status for the left shoulder in approximately 3-4 months.

While there was a claim for neck pain, she does not give me a history to support a cervical spine injury. There is no indication of any treatment for the neck in the records from the last year. The treatment has been for the shoulders only. She gives no neck complaints today. She gives no history of headaches to me today.

Ms. [redacted] has been seen by a rheumatologist and has a positive ANA. While I can see how she injured her shoulders due to the work described, I cannot relate any other complaints to the job.

FUTURE MEDICAL CARE:

The patient should be provided with future medical care for the left shoulder consisting of physical therapy to improve range of motion.

For the right shoulder, she should continue her home exercise program.

STATUS:

Ms. XXXXXX has reached maximum medical improvement for the right shoulder only.

AMA IMPAIRMENT:

Using the AMA Guides, 5th Edition, Figure 16-40 on page 476, she has a 3% upper extremity impairment. Using Figure 16-41 on page 477, abduction to 90 degrees equals a 4% upper extremity impairment. Her total right upper extremity impairment is 7%. There is no impairment for internal or external rotation. Using Table 16-3 on page 439, the upper extremity impairment of 7% converts to a 4% whole person impairment.

[redacted]

The left shoulder is not yet at maximum medical improvement and is not rated at this time.

WORK CAPACITY:

She would be precluded from use of the arms above shoulder level. She is also precluded from lifting, pushing or pulling more than 20 pounds.

CAUSATION & APPORTIONMENT:

Ms. [redacted] bilateral shoulder complaints are consistent with a continuous trauma work injury.

100% of the patient's present right shoulder disability is apportioned to her employment activities of repetitive overhead reaching. Her prior x-rays did not show any significant degeneration. At this time I feel there is no prior disability or other causation to apportion.

I see nothing to support any injury to the cervical spine. She also gives me no history of headaches or migraines due to neck pain. Any complaints other than to the shoulders I feel is more medical reasonably related to her positive ANA.

DISCLOSURE:

Ms. [redacted] was interviewed and examined by the undersigned. The medical records were reviewed and this dictation was done solely by the undersigned.

Sincerely,

KENNETH P. SCHEFFELS, M.D.
Diplomate, American Board of
Orthopedic Surgery

Signed in Los Angeles County on _____

KPS/fm/cce

September 23, 2015

TO: Disability Procedures & Services Committee
Vivian H. Gray, Chair
William de la Garza, Vice Chair
William R. Pryor
Les Robbins
Yves Chery, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services Division

FOR: October 7, 2015, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF THOMAS W. FELL, JR., M.D., AS LACERA PANEL PHYSICIAN**

On August 17, 2015, Debbie Semnanian interviewed Thomas W. Fell, Jr., M.D., a physician seeking appointment to the LACERA Panel of Examining Physicians.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s).

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of Thomas W. Fell, Jr., M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJ:RC/sc

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

Date: 9/24/15

August 17, 2015

TO: **Ricki Contreras, Division Manager**
Disability Retirement Services

FROM: **Debbie Semnanian, WCCP** DS
Supervising Disability Retirement Specialist

SUBJECT: **INTERVIEW OF ORTHOPEDIC SURGEON APPLYING FOR LACERA PHYSICIAN'S PANEL**

On August 17, 2015, I interviewed **Thomas Fell**, M.D. at his office at 4940 Van Nuys Blvd., Suite 302, Sherman Oaks, CA 91403. The office space is located in an older but well maintained three-story building with patient paid parking (maximum $6.00) located in the back of the building. There is also free 2-hour parking on the adjacent street.

Dr. Fell is a board certified orthopedic surgeon who has been in private practice for over forty years. Dr. Fell shares office space with several orthopedists and a neurologist. The office has 6 complete examination rooms. Dr. Fell estimates that 50 percent of his practice is devoted to patient treatment, while the other 50 percent of his time is devoted to IME evaluations primarily within the workers' compensation systems and other retirement systems.

As referenced in his Curriculum Vitae, Dr. Fell graduated from New Jersey College of Medicine with his medical degree in 1969. He completed an internship at North Carolina Hospital in 1974, and residencies at North Carolina Memorial Hospital in 1974 and North Carolina Orthopedic Hospital in 1973. Dr. Fell served as Chairman Quality Assurance Committee and Chief of Staff at Pacifica of the Valley Hospital.

Dr. Fell's office was clean with adequate seating. The office and restrooms are handicap accessible and there is a staff of thirteen employees.

Staff reviewed the LACERA Disability Retirement procedures and expectations in its evaluation of County Employees applying for both service-connected and nonservice-connected disability retirements. The importance of preparing impartial and non-discriminatory reports that are clear and concise and address issues of causation and incapacity were discussed with the doctor. He understood that he would adhere strictly to the HIPAA laws that would also apply for LACERA reports. Staff reviewed with Dr. Fell the Panel Physician Guidelines for evaluating LACERA applicants and defined the relationship between workers' compensation and disability retirement. Staff discussed the need to rely on his

own objective and subjective findings rather than the opinions of previous physician reports and/or comments.

Dr. Fell agreed to adhere to LACERA's standard of having his evaluation reports sent to us within 30 days of examination. Staff confirmed that Dr. Fell is agreeable with accepting payment per the Official Medical Fee Schedule (OMFS). Dr. Fell was informed that if he is approved by the Board to be on our panel of physicians, he is required to contact the specialist assigned to the case for approval of any special tests or extraordinary charges. He was also informed that a Quality Control Questionnaire is sent to each applicant regarding their visit.

RECOMMENDATION

LACERA has a pressing need to add orthopedic physicians, particularly in the area in which Dr. Fell completes examinations. He expressed not only a willingness to be on our panel, but also an enthusiasm for building a relationship with LACERA.

Based on our interview and the need for his specialty, staff recommends Dr. Fell's application be presented to the Board for approval as a LACERA Panel Physician.

LACERA

Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-2419 • 800/786-6464

GENERAL INFORMATION		Date 6-8-15
Group Name:		Physician Name: Thomas W. Fell JR. M.D.
I. Primary Address: 4940 Van Nuys Blvd #302 Sherman Oaks CA 91403		
Contact Person E. Moss		Title Administrator
Telephone: 818-990-4497		Fax 818-990-6045.
II. Secondary Address See Attached Listing.		
Contact Person		Title
Telephone		Fax

PHYSICIAN BACKGROUND

Field of Specialty Orthopedic Surgery	Subspecialty	
Board Certification ☒ Yes ☐ No	License # G26187	Expiration Date 10-31-16

EXPERIENCE

Indicate the number of years experience that you have in each category.

Evaluation Type

I. Workers' Compensation Evaluations

No liens

- ☒ Defense — How Long? 25 years.
- ☒ Applicant — How Long? 8 years
- ☒ AME — How Long? 8 years
- ☒ IME — How Long? 20 years.
- ☒ QME — How Long? 20 years.

II. ☒ Disability Evaluations — How Long? 20 years City of LA

For What Public or Private Organizations? Dept of Fire & Police Pensions (5 years → CAL PERS)

Currently Treating? ☒ Yes ☐ No

Time Devoted to: Treatment 50 % Evaluations 50 %

Estimated Time from Appointment to Examination

- ☐ 2 weeks
- ☒ 3-4 Weeks
- ☐ Over a month

Able to Submit a Final Report in 30 days?

☒ Yes ☐ No

LACERA's Fee Schedule

Examination and Initial Report by Physician	$1,500.00 flat fee
Review of Records by Physician	$350.00/hour
Review of Records by Registered Nurse	$75.00/hour
Supplemental Report	$350.00/hour

-OVER-

Other Fees	
Physician's testimony at Administrative Hearing (includes travel & wait time)	$350.00/hour
Deposition Fee at Physician's office	$350.00/hour
Preparation for Expert Testimony at administrative Hearing	$350.00/hour
Expert Witness Fees in Superior or Appellate Court	$3,500.00 half day $7,000 full day

Physician agrees with LACERA's fee schedule? Yes No

Comments

Name of person completing this form:

THOMAS W FELL, 5R MD (Please Print Name) Title: _____

Physician Signature: Thomas W Fell MD Date: 6-15-15

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date: 8/17/15	Interview Time: 12:00
Interviewer: Julie Simmons	

CURRICULUM VITAE

THOMAS W. FELL, JR., M.D.

Diplomate, American Board of Orthopedic Surgery

MAIN OFFICE:
Sherman Oaks
4940 Van Nuys Blvd.#302
Sherman Oaks, CA 91403
(818)990--4497

OTHER LOCATIONS:

Beverly Hills
50 N. La Cienega Blvd.#205
Beverly Hills, CA 90211
(323)966--4566

Arcadia
630 W. Duarte Road #203
Arcadia, CA 91007
(626)447-8870

Palmdale
819 Auto Center Drive
Palmdale, CA 93551
(661)266-0993

Paramount
16444 Paramount Blvd.#204
Paramount, CA 90723
(562)408-2247

Education:

Tufts University, Medford, Ma. B.S. 1964
Boston College, Chestnut Hill, Ma. Chemistry 1965
New Jersey College of Medicine, Newark M.D. 1969

Internship:

North Carolina Memorial Hospital Chapel Hill, N.C.
July 1969 - June 1970

Residency:

North Carolina Memorial Hospital Chapel Hill, N.C.
July 1970 - June 1974
North Carolina Orthopaedic Hospital Gastonia, N.C.
(Children's Orthopaedics) Jan-Dec 1973)

Practice:

Ross-Loos, Los Angeles July 1974 - August 1978
Serra Medical Clinic, Sun Valley 1978-May, 2004
Med Health (Workers Compensation - Treatment and Evaluations),
Sherman Oaks, Palmdale, Arcadia, Beverly Hills, Paramount
1988-Present

Hospital Affiliations:

Pacifica of the Valley Hospital, Sun Valley

Past Positions:

Director Scoliosis Clinic Ross-Loos(Cigna) 1974-84
Vice President Medical Staff Ross-Loos Hospital 1974
Chairman Utilization Review Ross-Loos Hospital 1973-74
Chairman Quality Assurance Committee Pacifica of
the Valley Hospital 1980-85, 1988-1989, 1994
Chief of Staff Pacifica of the Valley Hospital
1985-1987
Member Board of Directors Serra Medical Clinic 1979-1990
Chairman Department of Surgery Pacifica of the Valley Hospital 1989-91

Certification:

American Board of Orthopaedic Surgery, September 1975

Societies:

American Academy of Orthopaedic Surgeons
Western Orthopaedic Association

Licenses:

California, North Carolina

Publications:

Preston, E.T., and Fell, T.W.: Congenital Idiopathic Clubfoot, Clinical Orthopaedics 122:102, 1977

Sample

THOMAS W. FELL, JR., M.D.

Diplomate, American Board of Orthopedic Surgery

50 N. La Cienega Blvd., Suite 205
Beverly Hills, California 90211
(323) 966-4566

[redacted]

[redacted]

XXXX, CA XXXXX
Attn : [redacted]

RE: LXXXXXXX JXXXXXX VS [redacted]

CLAIMANT : LXXXXXX [redacted]
CLAIM NO : XXXXXXXXXXXX
WCAB NO : [redacted]XXXX
EMPLOYER : XXXXXXXXXXXXXXX
ACCT NO : XXXXXXX
D/INJURY : [redacted]
D/EXAMIN :

ORTHOPEDIC DEFENSE QME EVALUATION

Dear XXXXXXXXXXXXX:

Today, I had the opportunity to perform an orthopedic Defense (ADR) QME evaluation on [redacted]XXXXXX [redacted]XXXXXXX, in my Beverly Hills office. He gives me the following history with the assistance of an interpreter, XXXXXXXXXXXX with [redacted]XXXXXXXXXX [redacted].

This is a Complex Comprehensive Medical-Legal Evaluation (ML103) with the following three complexity factors being met: Four hours was spent on a combination of reviewing the medical records and in face-to-face time with the claimant. This report addresses the issue of medical causation with written request.

EMPLOYMENT AT TIME OF INCIDENT:

Mr. [redacted]XXXXXXX is a 64-year-old right hand dominant male employed by XXXXXXXXXXXXXXX [redacted] as a janitor for he thinks about one year and two months prior to his injury. However, for at least 20 years prior to that he has worked for the same building doing maintenance, but working for

[redacted]

another owner, he thinks that company was XXXXXXXXX. All the time he has been there, he has been doing building cleaning and maintenance.

HISTORY OF THE PRESENT INJURY:

The patient's first accident occurred in [redacted]. Prior to that, he did not have any back pain. At that time, he was lifting some heavy garbage bags. He had low back pain and treated at [redacted]. He was off work for at least seven to eight weeks. He believes his employer was XXXXX at that time. He has had back pain ever since then. He states that he takes medications to try to control his back pain. He states that the patient was going down both legs. He states that at that time, surgery was advised, but he declined it. He was given a back brace, which he has worn ever since.

In [redacted], he was lifting a heavy garbage bag, which was heavier than usual. The low back pain significantly increased. He again went to XXXXX. He was evaluated and had x-rays. He had chiropractic treatment, acupuncture treatment and physical therapy.

He had an epidural steroid injection at XXXXXX, which helped.

He continued working light duty up until the time he was seen by an attorney. In [redacted] the attorney sent him to a doctor who placed him off work.

He was then given various physical therapy and medications until the present time.

He states he is a little better than he was in January.

He states that they talked about surgery, but he is afraid of the surgery due to his diabetes as how he is walking and afraid he will not walk after surgery.

He has not returned to work since [redacted].

PRESENT COMPLAINTS:

The patient has mid and lower back pain with twisting,

bending, reaching and squatting. He is overall better with sitting. The pain radiates to both legs down to the calves and feet, particularly with walking over one to two hours. The pain can be in the right or left leg. There is no numbness, but occasional tingling in the legs. With walking, the pain in the hips/buttocks is the greatest pain. Coughing and sneezing does not cause any pain.

PAST MEDICAL HISTORY:

WORK INJURIES:

The patient had a prior work related injury in [redacted], as noted in the history, also to the low back with continued pain.

ILLNESSES:

The patient has a history of diabetes. The patient denies arthritis, cancer, heart or lung disease.

MEDICATIONS:

The patient is taking omeprazole and ibuprofen. He also takes medication for his diabetes.

ALLERGIES:

None.

SURGERIES:

None.

AUTO ACCIDENTS:

Denied.

SOCIAL HISTORY:

The patient denies smoking cigarettes, but admits to drinking alcoholic beverages.

[redacted]

FAMILY HISTORY:

The patient's mother is alive with diabetes. The patient's father is deceased due to kidney problems.

REVIEW OF MEDICAL RECORDS:

Mr. [redacted] completed an ADL form today and this was reviewed.

XXXXXXXXXXXXXXXXXXXXXX:

[redacted] XXXXXXXXXXXXX, Esq. Cover letter thanking me for the evaluation of the applicant as defense QME evaluator.

State of California/WCAB:

[redacted] State of California, Division of Workers Compensation/Workers Compensation Appeals Board Application for Adjudication of Claim. Claimed was injury to back while lifting bags on XXXXXXXX as a Janitor for XXXXXXXXXXXXXXXX [redacted].

XXXXXXXX XXXXXXXXXXXXXXXX:

[redacted]: XXXXXXXXX XXXXXXXXXXXXXXX, M.D. Patient presented with back pain for 2 days with no history of trauma and no pain radiation. On examination there was a 1 x 1 cm subcutaneous soft tissue mass in lumbar area. Assessment: 1) Backache 2) Diabetic foot exam. Patient to have CT of lumbar spine without contrast. Ibuprofen 600 mg. Follow-up in 2 weeks with primary medical doctor.

[redacted]: XXXXXXXXXXX XXXXXXXXXXXXXX, M.D. CT of Lumbar Spine. Impression: 1) Moderate central canal stenosis at L4-L5 with lateral recess stenosis at L5 on the left and intraforaminal nerve root compression of the L4 nerve root on the left, secondary to combined effects of hypertrophic degenerative facet disease at L4-L5 and Grade 1 anterolisthesis at L4-L5. 2) Hypertrophic degenerative facet disease L5-S1 bilaterally. 3) No evidence of demonstrable mass in paraspinous soft tissue. Findings noted axial images noting bilateral severe hypertrophic degenerative facet disease with bilateral hypertrophic facet disease at

[redacted]

L5-S1 more pronounced on left.

[redacted]: XXXXXXXXXXX XXXXXXXX, M.D. Called patient's home and spoke with [redacted]. Doing better. Suspect recent pain was muscle spasm. Offered physical therapy as did lifting at work. Patient to consider. Follow-up with Dr. Daly in October.

[redacted] XXXXXX XXXXXXXXX, M.D. Patient seen for diabetes mellitus. Noting cough for 2 weeks from dust. Said walks a lot at work and likes to exercise. CT of lumbar spine reviewed. Physical examination noted minimal tenderness at paraspinal area. Diagnosis: Spinal stenosis, lumbar area.

[redacted] XXXXXX XXXXXXXX, P.T. Physical therapy evaluation. Noted 6 months of low back pain. Felt related to work from using heavy machines and heavy lifting. Physical therapy modalities reviewed.

[redacted] XXXXXXX XXXXXXX, R.N. Complaining of severe back pain x 2 months. Appointment made to see Dr. AXXXXXXX.

[redacted]: XXXXX XXXXXXX. Patient stated that no pain when not working. Pain came on after a couple of hours at work. Worse when having to lift trash into container, each bag weighing 60-70 lbs with many trash bins to fill. Worse with walking on hard surfaces rather than soft/carpeted. Did not like wearing brace because gets too hot wearing it. Discussed use of TENS for pain management.

[redacted] XXXXXXXXX XXXXXXXXXXX, M.D. Progress note. Presenting with back pain to lower extremities for 2 months. Pain in right lumbar more than left. Better with rest and physical therapy. Associated numbness and tingling in feet. Meloxicam and ibuprofen did not help. Patient said asked supervisor to change his duties but need's doctor's note. Assessment: Lumbar spinal stenosis. Plan: 1) Modified duty for next 2 months. 2) Tramadol 50 mg. 3) Consider epidural steroid injection.

[redacted]. Dr. XXXXXXXXXX. Recent flare-up of back pain recently. Rarely ill but had episodes of intense pain that currently have halted ability to work on regular basis.

[redacted]

Physical examination noted tenderness to palpation at paraspinal muscle musculature region, especially on right. Patient with left lateral flexion and rotation. Assessment: Spinal stenosis, lumbar region. Advised temporary disability with time off work.

[redacted]: XXXXXXXXX XXXXXXXXX. Referred by Dr. XXXXXX. Two months chronic back pain now worsening. Assessment: Lumbar radiculopathy. 2) Essential hypertension. Plan: Methylprednisolone 4 mg oral dose pack ordered.

[redacted]: XXXXXXXXX XXXXXXXXX, N.P. Referred by Dr. XXXXXXX. Pain seen low back pain. Acute and intermittent low back pain with pain radiation to right lower extremity to right calf over past 3 months aggravated by lifting work as janitor. Assessment: 1) Arthropathy of lumbar facet. 2) Essential hypertension. 3) Lumbosacral radiculitis. Plan: Epidural steroid injection. Patient given instruction for pre-injection of no aspirin for one week and no blood thinners as well as instructions for his diabetes.

[redacted]: XXXXXXXXX XXXXXXXXXX, M.D. History and Physical for scheduled epidural steroid injection. Patient with history of low back pain, right greater than left leg pain.

[redacted] Dr. XXXXXXXXX. Pre- and Post-Operative Procedure: 1) Spinal stenosis of lumbar spine. 2) Lumbosacral radiculitis. Procedure: 1) Injection into epidural space of lumbar steroid. 2) X-ray fluoroscopic guidance for spine injection.

[redacted]: Dr. XXXXXXXXXX. Follow-up evaluation. Pain had progressed and now into buttocks and both legs where previously only in right leg. Began having pain in both legs 2 months ago. Pain described as cramping 5/10.

Said [redacted] lumbar epidural steroid injection gave only little benefit. Assessment: Low back and bilateral leg pain. L4-L5 spinal stenosis. Recommend second epidural steroid injection which he agreed to. Patient to continue with meloxicam and tramadol p.r.n. basis.

[redacted]: Dr. XXXXXXX. Patient seen prior to scheduled epidural steroid injection. Dietary indiscretions due to

[redacted]

back pain, leg cramps and stress. Paxil for increased frustration over back condition. Dr. Daly felt that patient's better control of his blood sugar would help pain. Possible surgery if no relief with injections.

[redacted]: Dr. XXXXXXX. Pre- and Post-Operative Procedure: 1) Spinal stenosis of lumbar spine. 2) Lumbosacral radiculitis. Procedure: 1) Injection into epidural space of lumbar steroid. 2) X-ray fluoroscopic guidance for spine injection.

[redacted]: XXXXXXXXXXX XXXXXXXX, L.V.N. Note. Patient brought form for bus pass to fill out regarding spinal stenosis. Primary care physician not available.

[redacted]: CXXXXXXXX XXXXXXXs. Patient dropped off Metro Application form for Dr. XXXXXXX to sign. Dr. XXXXXXX made referral for him to Spine Surgery.

[redacted]: Dr. XXXXXX. Noting leg cramps often at night. Diagnoses include spinal stenosis.

[redacted] XXXXXXXXX XXXXXXXX, M.D. Sent for surgical consultation by Dr. [redacted] Patient has had limited responses to epidurals. Temporary help with physical therapy, multiple different medications and epidural steroid injections. X-rays: Mild narrowing noted at L4-L5 disc space associated with slight spondylolisthesis. L5-S1 disc space may be slightly narrowed, but not well visualized. Discussion: The patient was noted to have severe lateral recess stenosis L4-L5 bilateral secondary to degenerative spondylolisthesis and milder left L5-S1 lateral recess stenosis. He was offered hemilaminotomies and medial facetectomies of the bilateral L4-L5 and left L5-S1. This was felt to be better than a fusion as primary complaint was leg pain. Also fusion could be considered at later date. Patient to consider and to let us know if he wants to proceed with surgery.

[redacted]: XXXXXXX XXXXXXXXXXX, M.D. X-ray of Lumbar Spine. Impression: Mild narrowing noted at L4-L5 disc space associated with slight spondylolisthesis. L5-S1 disc space may be slightly narrowed, but not well visualized.

[redacted]

[redacted]: Dr. XXXXXX. Dr. Daly noted that the patient had follow-up at the Spine Clinic. Period of disability considered but patient holding off for now.

[redacted]: XXXXXXXXX XXXXXX, LVN. Phone call with daughter. Patient stated did not want to apply for disability anymore.

[redacted]: XXXXXXX XXXXXXX. Patient called and wanted to cancel disability as already has upcoming appointment with a back specialist.

[redacted]: Dr. XXXXXg. Patient complaining of pain in bilateral legs from hips to ankles with numbness and feeling of tightness. Assessment: 1) Low back and bilateral leg pain. 2) L4-L5 spinal stenosis. Plan: Discussion with patient on options. Patient having difficulty deciding if should have surgery. Hesitant to proceed with more injections. To titrate nortriptyline to 50 mg qhs.

[redacted]: **XXXXX XXXXXXXX, M.D. Back pain from picking up trash on this date.** Relevant Past Medical History: The patient was noted to have had a CT of the lumbar spine on [redacted] for low back pain. Scout radiographs of the spine at that time noted very mild Grade I anterolisthesis of L4 on L5. CT and lumbar x-rays reviewed. Impression: 1) Lumbosacral radiculitis. 2) Lumbar facet arthropathy. Plan: Norco p.r.n. severe pain. Continue meloxicam. Refer to physical therapy. Repeat of x-ray of spine today. May require lumbar epidural steroid injection. Work Status: Modified duty, with lifting, pushing and pulling up to 25 lbs.

[redacted]: XXXX XXXXXXXXXXX, M.D. Complaint of low back pain. Patient currently working. Diagnosis: Lumbar radiculitis. Plan: MRI of lower back without contrast. Rule out herniated disc. Continue on modified duty.

[redacted] Dr. XXXXXXXX. PR-2. Patient said he was constantly on his feet and had severe back pain at work. Diagnoses: 1) Lumbar spondylosis. 2) Lumbar radiculopathy. Plan: 1) Sacrolumbar support. 2) Lab testing. 3) Continue with medications.

[redacted]

[redacted]: Dr. XXXXXXX. PR-2. Diagnoses: 1) Lumbar facet arthropathy. 2) Low back pain. 3) Lumbar radiculitis. Plan: Continue medication. Finish physical therapy. Refer to Pain Management for lumber epidural steroid injection.

[redacted]: Dr. XXXXXXXX. Pain Medicine Consult. Worsening back pain. Dr. CXXXXXXXXXX noted that he had seen this patient in [redacted] for low back and leg symptoms. Assessment: 1) Low back pain with leg fatigability. 2) L4-L5 spinal stenosis. Discussion: The patient previously had epidural steroid injection with benefit. Patient to be scheduled when authorization from Workers Compensation received.

[redacted]: Dr. FXXXXXXXX. No change in diagnoses. Continue Norco and meloxicam. Lumbar epidural steroid injection scheduled. Work Status: No lifting, pushing or pulling over 6 lbs.

[redacted] Dr. XXXXXX. Procedure Note. Pre- and post-operative diagnosis: Lumbar spinal stenosis. Procedure: 1) Injection steroid/anesthetic epidural, lumbar or caudal 2) X-ray fluoroscopy up to one hr.

[redacted] Dr. FXXXXXXX. PR-2. The patient's symptoms were improved. No change in diagnoses. Medications were refilled.

Also noted are reports on treatment for diabetes mellitus, type 2, erectile dysfunction, hypertension, eye exams, laboratory work-ups, and viral illnesses.

XXXXXXXX XXXXXXXXXXX:

[redacted]: Physical therapy evaluation and treatment

XXXXXXXX Radiology:

[redacted]: XXXXXXXXX XXXXXXXXX, M.D. MRI of the Lumbar Spine. Impression: 1) 6 mm disc bulge at L4-5 which together with mild to moderate facet arthropathy results in moderate spinal stenosis as well as moderate severe left and mild to moderate right neuroforaminal narrowing. 2) 3 mm broad posterior disc protrusions at L3-4 and LS-S1 without

[redacted]

evidence of spinal stenosis or neuroforaminal narrowing. 3) 4-5 mm anterolisthesis of L4 on L5. This is likely on the basis of facet arthropathy. 4) Mild to moderate bilateral facet arthropathy at L4-L5. 5) Disc desiccation at T11-T12, T12-L1, L3-L4, L4-L5 and LS-S1 with mild to moderate disc height loss at L4-L5.

Industrial XXXXXXXX XXXXXXXXXX:

[redacted]: XXXXXXXX XXXXXXXXXXXXX, M.D. Primary Treating Physician's Initial Comprehensive Medical Evaluation Report. The patient's injury was described. He presented with low back pain. He was currently TTD. Relevant Past Medical History: Type 1 diabetic. The patient injured his back 4 years ago while working for the employer and had self-procured treatment with injection and physical therapy (at Kaiser). He did not file a Workers Compensation claim at that time. Diagnosis: Lumbar spine myofascitis with radiculopathy. Plan: Omeprazole 20 mg q.d., Tylenol #3 300/30 mg 1-2 p.o. q 8-12 hrs, ibuprofen 800 mg 2-3 x daily. Physical therapy 2 x a week for 4 weeks. Functional Capacity Evaluation requested. DNA testing-CYP450 Pharmacological ASSAY for medication therapy ordered. Patient to have internal medicine consult for diabetes. Work Status: TTD.

[redacted]: XXXXXXXX XXXXXXXX, M.D. Internal medicine consult. Chest x-ray ordered.

[redacted]: Dr. XXXXXXXXXXXX. PR-2. No change in diagnoses. Labwork reviewed. Plan: EMG/NCV. Physical therapy 2-3 x a week for 4 weeks.

[redacted]: Dr. XXXXXXXXXXX. PR-2. No change. Patient referred for orthopedic consult.

[redacted] AXXXXXXX XXXXXXXXX, M.D. Secondary Treating Physician's Initial Comprehensive Orthopaedic Spine Evaluation. Chief Complaint: Low back pain following work injury with radiculopathic numbness and tingling of the lower extremities. The patient had been treated by Dr. De La Llanos conservatively. Diagnosis: 1) Lumbar disc herniation with discogenic disease and spondylolisthesis of L4-L5 with lytic lesions and pars defect. 2) Rule out

[redacted]

lumbar radiculopathy. Discussion: Dr. YXXXXXXXXXX requested all MRI reports. He considered the applicant to be a surgical candidate but wished to have nerve conduction studies of the lower extremity first.

This concludes the review of medical records.

PHYSICAL EXAMINATION:

GENERAL:

The patient appears to be his stated height of [redacted]'' tall and [redacted] pounds.

GAIT:

The patient walks without a limp.

STANCE:

On stance, the pelvis is level, the back is straight and the head is balanced over the midline.

CERVICAL SPINE:

Examination of the cervical spine reveals no tenderness in the midline. Paraspinal muscles are nontender without spasms.

There are no fascial nodules.

Trapezii are nontender without spasms.

Range of motion of the cervical spine reveals rotation to 60/60 degrees; lateral tilt to 30/30 degrees; extension to 30 degrees; and forward flexion - chin to the chest. All ranges of motion are without pain.

SHOULDERS:

Examination of the shoulder girdles reveals no tenderness to palpation. There is no evidence of atrophy or swelling.

Range of motion of the shoulders reveals abduction to

[redacted]

180/180 degrees; adduction to 50/50 degrees; forward flexion to 180/180 degrees; external rotation to 90/90 degrees; internal rotation to 80/80 degrees; and extension to 50/50 degrees.

Impingement, apprehension and biceps stress tests are negative.

Shoulder motor strength in flexion, extension, abduction, adduction, internal rotation, and external rotation are all 5/5.

ELBOWS:

Examination of the elbows reveals no tenderness or swelling.

Cubital tunnels are nontender.

Range of motion of the elbows reveals extension to 0/0 degrees; flexion to 150/150 degrees; pronation to 80/80 degrees; and supination to 90/90 degrees.

Elbow motor strength in flexion and extension is 5/5.

WRISTS/HANDS:

Forearms are nontender.

Examination of the wrists reveals no evidence of tenderness or swelling.

Range of motion of the wrists reveals dorsiflexion to 70/70 degrees and palmar flexion to 70/70 degrees.

Wrist motor strength in dorsiflexion and palmar flexion is 5/5.

Tinel's, Phalen's, and Finkelstein's tests are negative.

There is no evidence of thenar or hypothenar atrophy.

Abduction strength is strong.

He is able to bring all of his fingers to the mid-palmar

[redacted]

crease and his thumb to the fifth metacarpal head.

Reflexes: Biceps 1+/1+; triceps 1+/1+.

Pinprick sensation in the upper extremities is intact.

UPPER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Forearms :	24.5 cm	24.5 cm
Biceps :	27 cm	27 cm

LUMBAR SPINE:

The patient complains of mild left and right paraspinal tenderness. The sacroiliac joints are nontender.

There are no spasms. There are no fascial nodules.

Range of motion of the lumbar spine reveals the patient bends forward to the level of the ankles. Lateral tilt is to 20/20 degrees. Extension is to 10 degrees. With extension and lateral tilt, he has lateral radiating leg pain.

LOWER EXTREMITIES:

Reflexes: Knees 2+/2+; ankles 2+/2+.

Pinprick sensation in the lower extremities is intact.

The extensor halluces longus is strong.

The motor examination, including extensor halluces longus, hamstrings, quadriceps and hip flexors, are all 5/5.

Straight leg raising to 70/70 degrees.

Sciatic tension test is negative.

KNEES:

Examination of the knees reveals no evidence of swelling or localized tenderness.

Range of motion is without pain.

LOWER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Calves :	36.5 cm	36.5 cm
Quadriceps (4'' above The superior pole of The patella) :	40 cm	40 cm

DIAGNOSIS:

Lumbosacral sprain/strain aggravating underlying degenerative arthritis with stenosis.

DISCUSSION:

This patient has underlying preexisting degenerative arthritis of the lumbar spine with Grade I anterolisthesis at L4-L5 with canal and foraminal narrowing, with stenotic symptoms. He first injured his back in [redacted]. The pain was aggravated by work at that time. His symptoms were stenotic at that time with pain going down the leg. His diagnosis was lumbar spinal stenosis. In spite of his diabetes, he was given a Medrol Dosepak. He was given epidural steroid injections, which did not help that much. Following the 2010 injury, due to the ongoing pain, he was sent for surgical consultation and surgery was advised. The patient declined surgery at that time and he is still declining it at this time.

The patient has had ongoing pain since [redacted]. He then clearly suffered a new injury of [redacted]. It does appear that the back pain increased at that time, although it does not really appear his leg pain increased. With the epidural steroid injection he did improve somewhat. With not working since December, he has improved a little bit also.

Since the patient does not want surgery, nothing more can be

[redacted]

done for this patient and he is at maximum medical improvement.

FUTURE MEDICAL CARE:

The patient should be allowed to use non-steroidal anti-inflammatory medications permitted by his diabetic and hypertension condition. Allowance should be made for one to two more lumbar epidural steroid injections show the symptoms increase. The option for decompressive surgery as suggested by XXXXXXX XXXXX in [redacted] should be left open since he is having very stenotic symptoms since [redacted]. The need for surgery has been present since the [redacted] injury and would be indicated absent the [redacted] injury.

AMA IMPAIRMENT:

Using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

For completeness, I would recommend electrodiagnostic studies be obtained of the bilateral lower extremities to be sure the patient does not have any true radiculopathy. I expect that the EMG would be negative and if so, he would be rated according to the DRE method Table 15-3, he would be DRE category II with 8% whole person impairment.

WORK STATUS:

The patient could return to limited duty with no lifting over 25-pounds, no repetitive bending or stooping at the waist. The patient should be allowed to sit periodically and avoid very prolonged standing. He should be allowed just to sit for 5-10 minutes every hour or so just to relieve the stenotic symptoms in his legs.

CAUSATION & APPORTIONMENT:

The patient aggravated pre-existing symptomatology and pathology in the episode of [redacted] at XXXXXXX XXXXX [redacted] However, he already had significant stenotic symptomatology with radiating leg pain. He was taking medications prior to August of [redacted]. He had increased symptoms since his prior injury of [redacted]. Absent the episode

[redacted]

of [redacted] he was able to continue working on light duty indicating a worsening of his back pain. I would apportion 20% to the episode of [redacted] and 80% to the combination of prior injury of [redacted] and preexisting pathology. To make clear, the need for surgery existed since [redacted] and still exists at this time, and would have existed absent the episode of August of [redacted]. The patient's stenotic symptoms were present in [redacted] and have persisted ever since then. The reason for surgery is decompression of the lumbar spine due to the stenotic symptoms. These stenotic symptoms were present in [redacted] and persist at this time.

DISCLOSURE:

This patient was interviewed and examined by the undersigned, with the assistance of professional interpreter, XXXXXX XXXXXXX with XXXXXXX Interpreting. The medical records were reviewed; and this dictation was done in its entirety by the undersigned.

The attached statement for billing for the services of this evaluation and report are true and correct to the best of my knowledge. There has not been a violation of Sec. 139.3 in conjunction with this evaluation to the best of my knowledge.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Sincerely,

THOMAS W. FELL, JR., M.D.
Diplomate, American Board of
Orthopedic Surgery

Signed in Los Angeles County on _____

TWF/rb/mte

cc: XXXXXXXXXX XXXXXXXX
PO Box XXXXX
SXXXXXXXXX, XX XXXXX
Attn: LXXX HeXXXX

Sample Report #2 Pension

THOMAS W. FELL, JR., M.D.

Diplomate, American Board of Orthopedic Surgery

4940 Van Nuys Boulevard, Suite 302
Sherman Oaks, California 91403
(818) 990-4497

[redacted]XXXX

CITY OF XXXXXXXXXXXX
[redacted] XXXXXXXXXXXXX[redacted]
XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX

Attn: XXXXXXXXXXXX,[redacted]

CLAIMANT : XXXXXXXXX XXXXXXXX
CLAIM NO : FLA-XXXX
EMPLOYER : XXXXXX
ACCT NO : [redacted]
D/EXAMIN :

ORTHOPEDIC EVALUATION –[redacted]

Dear Mr. XXXXXXX:

Today, I had the opportunity to perform an orthopedic evaluation on [redacted]XXXXXX, in my Sherman Oaks office. He gives the following history.

He is seen for evaluation of his "right knee, elbows, feet, back and neck".

EMPLOYMENT AT TIME OF INCIDENT:

Mr. XXXXXXX is a 63-year-old right hand dominant male employed by the XXXX for 16-years. He joined the [redacted] in [redacted] working patrol for three to four years. After that he worked in a special unit of firearm tracking for approximately five years. In [redacted] he became a detective and worked in that position until [redacted]. He became a sergeant on patrol for two years, which was mainly supervisory. He tried not to participate, but occasionally had to participate. He went back to detective work for his last year of employment, last working in [redacted] One year later he took his retirement.

[redacted]

HISTORY OF THE PRESENT INJURY:

Mr. XXXXXXX tells me he stopped working in [redacted] mainly due to a combination of his right knee and his heart problems.

Mr. XXXXXXX has had problems with the cervical spine (neck) for seven to eight years. It was insidious in onset. He feels this is related to his job. He states he was wearing a helmet monthly for the last three to four years when he was on patrol and as a sergeant and for the first three to four years.

The bilateral elbow pain specifically began in [redacted] when his unit had a large gun recovery of 17+ tons. He had to constantly move the inventory over a three month period. During that time, he developed bilateral elbow pain. This pain became so severe he could not even lift a cup of coffee.

He was treated with physical therapy and injections.

Eventually in [redacted] he had bilateral elbow surgery by Dr. ZXXXXX. He had postoperative physical therapy. The surgery helped, but never took away all of his pain. He was told by Dr. ZXXXX that he might need more surgery due to the amount of scar tissue that built up over the years. However, since then, he has had no more treatment other than medications.

The lumbar spine (back) has no specific injury and just insidious pain over time. He states the low back radiates to the right buttocks, and down to the right leg, as well as left sided lower back pain at times.

In [redacted] or [redacted] he began treatment with Dr. GXXXX for his back. He had physical therapy and x-rays. He is not sure if he had an MRI, but he was told he had bulging discs.

Injections in the back were offered, but he declined them. He was worried about his heart.

He first injured his right knee in [redacted], prior to XXXX, when he twisted it. He had two surgeries. He had surgeries for bone chips and torn cartilage. The chips were apparently laterally and pinned back in place. He had a second surgery to take out the pins and then a third surgery to scrape out the excess calcium. He states that he did okay until [redacted] when he was working and stepping out of a car into a hole and the knee popped. He had three days off work at that time. He was told he had a sprain and always since then has had some swelling and pain.

[redacted]

In [redacted] he further injured his right knee. In [redacted] he stepped on something in a parking lot and twisted his knee and fell. About a month later he was running and stubled and again injured the right knee. Ever since then, he has had more knee pain. He had x-rays and an MRI and was told his cartilage was gone and that it was bone on bone. Synvisc did not really help. He found that he was allergic to it.

He has had no further surgeries on the right knee. He was told that the only thing that will help his knee is a total knee replacement when the knee becomes bad enough.

He also has bilateral feet plantar fasciitis pain. He states that this began in [redacted] when he went from boots to a shoe as detective. He has had x-rays. No injections have been offered. He has had tape and orthotics by a podiatrist.

PRESENT COMPLAINTS:

He reports cervical spine pain, left greater than right, when turning his head. He is okay with forward motion. Looking over his shoulder to drive is what gives him the most trouble. There is no radiating pain. He gets numbness in the ulnar two fingers right and left episodically with a lot of use. This is not a constant pain.

The bilateral elbows - left equal to right have lateral pain. There is tenderness over the scar. The pain increases with a lot of use and cold weather. Lifting particularly away from his body causes pain.

Lower back pain. The left lower back pain is greater, but he has right greater than left buttocks pain that radiates to the knee posteriorly and to the groin anteriorly. This occurs with bending, squatting, lifting and cold weather, as well as twisting, vacuuming and sweeping and sitting without support. He gets numbness in the anterior lateral thigh at times. Coughing and sneezing causes pain up and down spine from his heart surgery, but also causes some lower back pain.

The right knee has swelling, stiffness and pain medial greater than lateral, increased with any use of the leg. The right knee locks and buckles. He has marked difficulty with stairs, squatting and kneeling. He lacks full motion of the knee.

There is left greater than right plantar heel pain with walking over one half hour. He describes a burning pain that is better when he soaks them in cold water.

[redacted]

PAST MEDICAL HISTORY:

WORK INJURIES:

As noted above with the XXXXX as well as the right knee injury in the XXXXX.

ILLNESSES:

He has a history of coronary artery disease, atrial fibrillation, hypertension, sleep apnea, a hiatal hernia, and arthritis of the right knee, hearing loss, gastrointestinal problems, Barrett's syndrome. He denies diabetes or cancer. He has a pacemaker.

MEDICATIONS:

He is taking Arcapta, Benazepril, hydrochlorothiazide, Bystolic, Crestor, Cymbalta, Levothyroxine, Nexium, Advair, Amiodorone, Cidaflex, CoQ10, Lovaza, Xopenex HFA, aspirin, Finasteride, Montelukast, Lunesta, Temazepam, Valtrex, Xodol, Welchol and Amoxicillin.

ALLERGIES:

None.

SURGERIES:

He has had a replacement of the aortic valve in [redacted] He also had bilateral elbow surgery, as noted in the history. He also had a fractured left clavicle in [redacted] requiring surgery. He had right knee surgery in [redacted] and [redacted], as noted in the history.

AUTO ACCIDENTS:

Denied any with injuries.

SOCIAL HISTORY:

The patient denies smoking cigarettes or drinking alcoholic beverages.

[redacted]

FAMILY HISTORY:

The patient's [redacted] is decease from an abdominal aneurysm and the patient's father is deceased from stroke.

REVIEW OF MEDICAL RECORDS:

[redacted] XXXXXXXXXX, [redacted] Cover letter reviewed.

Extensive records were also submitted and review as follows: B1-B9; D1-D17; E1-E1303.

PHYSICAL EXAMINATION:

GENERAL:

XXXXXXX appears to be his stated height and weight of [redacted]" tall and [redacted] pounds.

GAIT:

The patient has an antalgic gait on the right side. He is wearing a right knee brace.

STANCE:

On stance, the pelvis is level, the back is straight and the head is balanced over the midline.

CERVICAL SPINE:

The patient complains of right and left paraspinal tenderness.

There are no fascial nodules.

Trapezii are nontender without spasms.

Range of motion of the cervical spine reveals rotation to 50/50 degrees; lateral tilt to 20/20 degrees; extension to 20 degrees; and forward flexion -1 fingerbreadth chin to the chest.

Foraminal compression test is negative.

[redacted]

SHOULDERS:

Examination of the shoulder girdles reveals no tenderness to palpation. There is no evidence of atrophy or swelling.

Range of motion of the shoulders reveals abduction to 180/180 degrees; adduction to 50/50 degrees; forward flexion to 180/180 degrees; external rotation to 90/90 degrees; internal rotation to 80/80 degrees; and extension to 50/50 degrees.

Shoulder motor strength in flexion, extension, abduction, adduction, internal rotation, and external rotation are all 5/5.

ELBOWS:

There are well healed lateral scars that are diffusely tender.

There is a mildly positive Cozen's test bilaterally. There is negative reverse Cozen's test. Tinel's is negative at the elbow.

Cubital tunnels are nontender.

Range of motion of the elbows reveals extension to 0/0 degrees; flexion to 150/150 degrees; pronation to 70/70 degrees; and supination to 70/70 degrees.

Elbow motor strength in flexion and extension is 5/5.

WRISTS/HANDS:

Forearms are nontender.

Examination of the wrists reveals no evidence of tenderness or swelling.

Range of motion of the wrists reveals dorsiflexion to 70/70 degrees and palmar flexion to 70/70 degrees.

Wrist motor strength in dorsiflexion and palmar flexion is 5/5.

Tinel's, Phalen's, and Finkelstein's tests are negative.

There is no evidence of thenar or hypothenar atrophy.

Abduction strength is strong.

He is able to bring all of his fingers to the mid-palmar crease and his thumb to the fifth metacarpal head.

Reflexes: Biceps 1+/1+; triceps 1+/1+.

To the Wartenberg wheel he had slight decreased sensation in the right index and left 5th fingers. However, he has 5 mm two-point discrimination in all fingers.

Jamar Grip Strength Testing

Right/Left= 30/22; 26/26; 29/26

UPPER EXTREMITY MEASUREMENTS:

		RIGHT	LEFT
Wrists	:	19 cm	19 cm
Forearms	:	32 cm	32 cm
Biceps	:	39 cm	32 cm

LUMBAR SPINE:

The patient complains of left and right paraspinal tenderness. The sacroiliac joints are nontender.

There are no spasms. There are no fascial nodules.

Range of motion of the lumbar spine reveals the patient bends forward to the level of -2" above the ankles and back to the erect position quickly and easily. Lateral tilt is to 20/20 degrees with ispilateral pain. There is no radiating pain in the lower extremities. Extension is

[redacted]

to 20 degrees.

LOWER EXTREMITIES:

Reflexes: Knees 2+/2+; ankles 2+/2+.

Pinprick sensation is slightly decreased on the anterolateral nerve distribution on the right.

The extensor halluces longus is strong.

The motor examination, including extensor halluces longus, hamstrings, quadriceps and hip flexors, are all 5/5.

Straight leg raising to 60/60 degrees.

Sciatic tension test is negative.

LEFT KNEE:

The left knee is entirely nontender with mild patellofemoral crepitus on range of motion.

Range of motion of the knee reveals extension to -2/0 degrees and flexion to 125/135 degrees.

RIGHT KNEE:

There is a long para-medial scar and a shorter lateral scar. The knee rests in approximately 7-degrees of valgus. There is moderate effusion of the knee.

The knee is stable to anteroposterior and mediolateral stressors. With valgus stress there is pain.

McMurray's, jerk and patellar apprehension tests are all negative.

BILATERAL FEET:

There is mild plantar fascial tenderness bilaterally.

[redacted]

LOWER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Calves :	38 cm	39 cm
Knees (mid-patella) :	44 cm	43 cm
Quadriceps (4" above The superior pole of The patella) :	54 cm	55 cm

DIAGNOSIS:

1. Degenerative arthritis of the right knee, status post surgery times three.

2. Cervical spine degenerative disc disease.

3. Lumbar spine degenerative disc disease.

4. Bilateral lateral epicondylitis, status post extensor release and debridement.

5. Bilateral plantar fasciitis.

DISCUSSION:

Mr. XXXXXXX has multiple problems that he relates to his work with XXXXX.

He does have problems with the bilateral elbows as a result of his bilateral traumatic epicondylitis that is still symptomatic.

The major problem at this point is his right knee. He had lesser problems with the cervical spine and lumbar spine. In regard to the cervical spine and lumbar spine, this is an insidious onset with some mild age related degenerative arthritis.

He also brings in some slight numbness in the anterior lateral aspect of the right thigh. This is Meralgia paresthetica due to obesity and not related to employment.

[redacted]

With regard to the feet he has bilateral plantar fasciitis that he states developed in [redacted] having treatment in [redacted], while he was on desk duty.

In regard to the right knee, he injured his right knee in the [redacted] in the [redacted] and damaged his cartilage at that time. He has had a progression of arthritis of the right knee that stayed relatively asymptomatic until the injury of [redacted] At that time he lit his arthritis up a little bit. He significantly lit up his underlying arthritis in the injury of [redacted]

The bilateral elbows were injured in the specific episode in [redacted] and somewhat improved with the surgeries, but are still symptomatic and I expect to be ongoing with symptoms due to the lack of complete recovery in spite of the surgery.

INCIDENTS CAUSING IMPAIRMENT:

The cervical spine and lumbar spine have no specific incident causing impairment. He has normal degeneration expected with his age. I would expect a mild aggravation of the cervical spine and lumbar spine due to the work activities, particularly when he was on patrol. However, the predominant cause of the cervical and lumbar complaints is normal degenerative arthritis with time.

The elbows are entirely due to the work episode of [redacted]. There is no evidence of preexisting pathology.

The right knee is due to a combination of the degeneration and due to the injury in the [redacted] and surgeries of the [redacted] with significant aggravation due to his employment in the episodes of [redacted] and further in the two episodes of [redacted] The episode of [redacted] aggravated preexisting arthritis. The episodes of [redacted] further aggravated the preexisting arthritis that would have existed without his employment. However, the significant arthritis seen is due to the cartilage damage in the [redacted]

With regard to his feet, I cannot see where working as a detective would have caused bilateral plantar fasciitis. Changing from boots to walking shoes would not be expected to cause plantar fasciitis. The records that have been supplied to me showed him being treated in [redacted] with taping of the right foot. The records that I have do not show his symptoms beginning with a change in shoes in [redacted] but show the symptoms probably beginning in [redacted] r [redacted] while he was working a sedentary job as a detective.

PRESENT IMPAIRMENT:

As a result of the right knee, he is precluded from anything more than one half hour of standing or walking at one time. He cannot do any type of repeated squatting, kneeling or climbing. He can only do very minimal stair climbing. This is based upon the objective findings found at the time of my examination, as well as the findings in the medical records.

For the bilateral elbows, he cannot do any heavy gripping or grasping without significantly aggravating his bilateral elbow symptomatology. He also cannot do lifting more than 25 pounds. He cannot do prolonged typing. I would not allow him to type for more than one half hour at a time without a 10-15 minute break and no more than 3-4 hours in one day. Typing is an activity with repetitive flexion and extension that will aggravate his elbows.

The cervical spine and lumbar spine has no additional preclusions beyond that already given for his elbows and his knee.

No other preclusions beyond what was already given for the right knee are needed for the bilateral feet.

MEDICAL REHABILITATION:

In regard to the elbows, I do not expect any further change with time.

For the neck and low back, I do not expect a change with time.

For the feet, he may improve slightly with some injections in the feet.

For the right knee, the symptoms will stay the same. When the symptoms become severe enough, he will need a total knee replacement. The total knee replacement will not significantly change his level of disability.

DISCLOSURE:

Mr. xxxxxxxxxx was interviewed and examined by the undersigned; the medical records were

[redacted]

reviewed; and this dictation was done in its entirety by the undersigned.

Sincerely,

THOMAS W. FELL, JR., M.D.
Diplomate, American Board of
Orthopedic Surgery

Signed in Los Angeles County on _____

TWF/rb/mte

October 19, 2015

TO: Each Member
Board of Retirement
Board of Investments

FROM: Gregg Rademacher
Chief Executive Officer

FOR: Board of Retirement Meeting of November 4, 2015
Board of Investments Meeting of November 10, 2015

SUBJECT: The 13th Annual Made in America: 2016 Taft-Hartley Benefits Summit on January 24-26, 2016 in Las Vegas, Nevada

The Financial Research Associates will be hosting its 13th Annual Made in America: 2016 Taft-Hartley Benefits Summit on January 24-26, 2016 in Las Vegas, Nevada at the Wynn Las Vegas. The Summit will include two comprehensive tracks – one on pension and annuity investment and another on health and welfare funds.

The main conference highlights include the following:

- Creating a Defensive Portfolio
- Diversifying Assets
- Private Equity Investing
- Hedge Funds and Taft-Hartley Plans: Value, Risk, Fees, and Returns
- Latest Legal and Regulatory Update
- The Heroin Epidemic and Your Benefit Plan

The conference meets LACERA's policy of an average of five (5) hours of substantive educational content per day excluding travel days. The registration fee is $695 for Board members. The conference group rate at the Wynn Las Vegas is $219.00 per night plus applicable taxes when made by December 23, 2015 or when the block of rooms is sold out, whichever comes first. The standard hotel rate is $279.00 per night plus applicable tax for reservations made thereafter.

If the registration fee is insufficient to pay the cost of the meals provided by the conference sponsor, LACERA must reimburse the sponsor for the actual cost of the meals, less any registration fee paid. Otherwise, the attendee will be deemed to have received a gift equal to the value of the meals, less any registration fee paid, under California's Political Reform Act.

IT IS THEREFORE RECOMMENDED THAT YOUR BOARD:

Approve attendance of Board members at the 13th Annual Made in America: 2016 Taft-Hartley Benefits Summit on January 24-26, 2016 in Las Vegas, Nevada and approve reimbursement of all travel costs incurred in accordance with LACERA's Education and Travel Policy.

GR/bn
Attachment

Financial Research Associates and Healthcare Education Associates presents

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The 2016 Taft-Hartley Benefits Summit

January 24-26, 2016 **Wynn Las Vegas**

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Why You Cannot Miss MIA 2016

Financial Research Associates' ***Made in America, the 13th Annual Taft-Hartley Benefits Summit***, scheduled for January 24-26, 2016 at The Wynn Hotel in Las Vegas, is the ***only Taft-Hartley event that puts politically correct antics aside and tells it like it is*** to the people who need to know straight-forward information—the fund Trustees and Administrators. Essentially, MIA 2016 is two conferences in one ; "Track A" attacks all the investment issues challenging your fund today while the "Track B" confronts all the health & welfare topics plaguing your fund.

What is MIA's Purpose?

Drawing from research with hundreds of past attendees and our sixteen advisory board members, we've worked hard to improve the program content, speakers, networking activities, and provide the best possible experience for our attendees. We are dedicated to delivering no-nonsense, solution-driven information Trustees and Administrators need-to-know.

A Few Summit Highlights Include:

Track A "Investment Issues" highlights:

- Looking beyond plain vanilla investments to dig out of your underfunded status
- Learning how to build a defensive portfolio for long term success
- Safeguarding your risky decisions - - will 7.5% return with a 10% volatility work for you?
- Chicken or the egg: actuarial assumption vs. investment allocations
- Private equity investing: What can you expect from 2016?
- Scrutinizing the value and risk of hedge funds for your TH plans
- How to secure low volatility equity? Does it exist?
- Taking the auto-pilot out of outsourcing CIOs
- Aligning economics and job creation with impact investing
- Today's global market conditions and concerns
- Real estate risks and ROIs – what should you expect?
- Calming fears and anxieties for troubled funds

Track B - - "Health & Welfare":

- Realities, nuances, and preparation for the excise tax
- Effectively monitoring funds to lower costs
- Everything you need to know about disease management and wellness programs
- Learning to calculate the ROI of disease management and wellness programs
- Lowering drug costs
- How do you determine who gets specialty drugs, how do you manage them, and when do you consider stop-loss?
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See for yourself what all the buzz is about! Register today! Call 800-280-8440 or online at www.frallc.com.

Sincerely,

Laura Garza

Laura Garza, *Conference Director*

FINANCIAL RESEARCH ASSOCIATES

P.S. Our BOGO offer last year helped us reach our 60:40 goal of funds to vendors ratio. We will be offering the ***buy one get one free*** *registration offer again*

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- Trustees and Board members
- Financial committee members
- Executive committee members
- Administrators and office managers
- Counsel

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- Taft-Hartley consultants
- Real estate advisors
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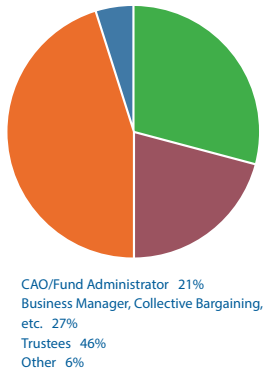

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- Network with hundreds of the brightest minds in the Taft-Hartley industry
- Hear renowned experts discuss the most current topics in both the pension investing and the health and welfare spaces
- Get usable and out-of-the-box strategies to overcome your underfunded status
- Stop getting watered-down, politically correct advice and hear industry leaders deliver the information you need to know to survive these turbulent times
- Minimize the impact of the excise tax on your fund
- Find out how you can get better results from your wellness program
- Scrutinize the risk/return profile for all your alternative investment allocations
- Uncover hidden and unconventional ways to cut plan costs
- Take advantage of our buy-one, get-one free registration for Taft-Hartley Trustees and Administrators
- Register today and find out why the momentum for this event continues to grow every year

Sponsorship and Exhibit Opportunities

Enhance your marketing efforts through sponsoring a special event or exhibiting your product at this event. We can design custom sponsorship packages tailored to your marketing needs, such as a cocktail reception or a custom-designed networking event.

To learn more about sponsorship opportunities, please contact Jennifer Clemence at 704-341-2438 or jclemence@frallc.com

For Taft-Hartley Plan administrators/trustees to take advantage of the **BUY ONE, GET ONE FREE** offer - please call Whitney Betts at 704-341-2445 or email her at wbetts@frallc.com. This offer is valid until 12/20/15. Website registrations cannot be accepted for this offer.

Discounts will also not apply.

AGENDA-AT-GLANCE

DAY ONE: SUNDAY, JANUARY 24, 2016

12:30 – 3:00 Exhibits Set-Up

3:30-6:30 AFC-NFC Championship Party

DAY TWO: MONDAY, JANUARY 25, 2016

7:45-8:20 Registration & Breakfast

8:20 "Welcome!"

	Track "A" Pension & Annuity Topics	Track "B" Health & Welfare Benefits
8:20 – 8:30	**Co-Chair's Opening Remarks:**	**Co-Chair's Opening Remarks:**
8:30 – 9:20	**Opening Panel: Digging Out of Your Underfunded Status**	**Preparing for the Realities of the Cadillac Tax: How Will It Play Out?**
9:20 – 9:30	*Transition Time*	*Transition Time*
9:30 – 10:30	**Creating a Defensive Portfolio: Learning to Balance Downside Risk Against Upside Potential**	**Looking at Cost-Containment Programs That Actually Work**
10:30 – 10:45	*Morning Break*	*Morning Break*
10:45 – 11:30	**Measuring Your Performance Against Your Own Risk and Return Objectives**	**Case Study: Disease Management From A to Z**
11:30 – 12:15	**What Comes First, the Actuarial Assumption or the Investment Allocation?**	**Wellness Cost, Screening, Incentives and So Much More**
12:15 – 1:30	*Luncheon for All*	*Luncheon for All*
1:30 –2:15	**Private Equity Investing: What Should You Expect for 2016?**	**Evaluating the ROI of Disease Management and Wellness Programs Managing Prescription Drug Costs and Potential Abuses**
2:15-3:00	**Hedge Funds and Taft-Hartley Plans: Value, Risk, Fees, and Returns**	
3:15-3:30	*Afternoon Break*	*Afternoon Break*
3:30 – 4:15	**Low Volatility Equity: Can You Have Your Cake and Eat it Too?**	**Specialty Drugs and How To Manage Them**
4:15-5:15	**End of Day Two Cocktail Reception Immediately**	**End of Day Two Cocktail Reception Immediately**

DAY THREE: TUESDAY, JANUARY 26, 2016

8:00 – 9:15 Morning Continental Breakfast & Breakfast Roundtable

	Track "A" Pension & Annuity Topics	Track "B" Health & Welfare Benefits
9:15 – 10:00	**Outsourcing CIOs: No Such Thing as Auto-Pilot Mode - - Actively Monitoring Your Portfolio**	**MIA's Legendary Administrators' Roundtable**
10:00 – 10:10	*Transition Time*	*Transition Time*
10:10 – 10:50	**Aligning Social and Investment Objectives: Working Toward Economic Stimulation and Job Creation through Impact Investing**	**NCCMP Speaks Out: Taking a Close Look at the Latest Legal and Regulatory Update**
10:50 – 11:05	*Morning Break & Hotel Check-Out*	*Morning Break & Hotel Check-Out*
11:05 – 11:50	**Global Market Conditions and Concerns**	**Mental Health Cost and Treatment for Addiction: What is the Impact on Your Fund?**
11:50 – 12:30	**Real Estate Gems and Over-Exposed Investments**	**The Future of Tele-Health**
12:30 – 1:45	*Luncheon for All MIA Attendees (Exhibit Hall Closes)*	*Luncheon for All MIA Attendees (Exhibit Hall Closes)*
1:45 – 2:30	**Diversifying Assets: Next Generation Fixed Income Strategies**	**The Heroin Epidemic and Your Benefit Plan**
2:30 – 3:15	**Dispelling Rumors and Calming fears for an Insolvent Fund and Lower Hours**	**Topic to be Announced**
3:15	*End of MIA 2016*	*End of MIA 2016*

The Made in America 2016 Advisory Board Members

A very special thanks to the Made in America Advisory Board members for dedicating their free time, thoughts and invaluable contributions to the content and quality of Made in America 2016.

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Andy Johnson, *Fund Administrator,* **Teamster Center Services Fund**, New York, New York

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Charlie Waibel CFA, *Managing Director*, **Sellwood Consulting LLC**, Portland, Oregon

Venue Details

Wynn Las Vegas
3131 Las Vegas Blvd. South
Las Vegas, NV 89109
p: 702-770-7000

We have a limited number of hotel rooms reserved for the conference. The negotiated room rate of $219 per night will expire on December 23, 2015 although we expect the block to sell out prior to this date. To ensure you receive a room at the negotiated rate book well before the expiration date. Upon sell out of the block room rate and availability will be at the hotel's discretion.

About the Venue:

Wynn Las Vegas holds more Forbes Travel Guide Five Star awards than any other independent hotel company in the world. Wynn Las Vegas offers award-winning restaurants, exciting entertainment and nightlife, a pristine 18-hole golf course, two award-winning spas, salons and luxury shopping. Their commitment to making every visit a once-in-a-lifetime experience to their guests is what makes them who they are.

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- Three people will receive 10% off
- Four people will receive 15% off
- Five people or more will receive 20% off

In order to secure a group discount, all delegates must place their registrations at the same time. Group discounts cannot be issued retroactively. For more information, please contact Whitney Betts at 704-341-2445 or wbetts@frallc.com

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- Anthony Rizzuto, *Founder and Executive Director*, **Families In Support of Treatment**
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- Glenn Ezard, *Senior Consultant*, **Segal Rogerscasey**, Los Angeles, Califorina
- Phillip A. Romello, Senior *Vice President and Actuary*, **Segal Consulting**, Washington DC
- Emily E. Johnstone, *Managing Director*, **AFL-CIO Housing Investment Trust**
- Jeffrey Pettiford, *Managing Member, Investor Relations* , **Window Rock Capital Partners, LLC**
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- Tom Costello, *Vice President, Stop Loss Sales*, **Symetra Life Insurance Company**
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- Ruth Donahue, *Vice President and Consultant*, **Segal Consulting**
- Sally Reppucci, *Executive Vice President - Operations and Technology*, **Renalogic**
- Samuel J. Kenish, CEBS, *Administrator*, **Teamsters Local 830 Employee Benefit Funds**
- Steven Villella, *Managing Director*, **Touchstone Consulting Group, Inc.**
- Tom Lamb, *Administrator*, **Law Enforcement Health Benefits, Inc.**

DAY ONE: SUNDAY, JANUARY 24, 2016

12:30 – 3:00 **Exhibits Set-Up**

3:30-6:30 **AFC-NFC Championship Party**

Contact Jennifer Clemence for more information on our sponsorship opportunities at jclemence@frallc.com or 704-341-2438

DAY TWO: MONDAY, JANUARY 25, 2016

7:45-8:20 **Registration sponsored by** Magellan Rx Management

7:45-8:20 **Breakfast sponsored by** renalogic

8:20 **"Welcome!"**

Track "A"
Pension & Annuity Topics

8:20 – 8:30 **Co-Chairs' Opening Remarks:**

John S. Shanklin, *CFA, CAIA, Senior Consultant*
NEPC, Las Vegas, Nevada

John Ulrich, *President*
Ulrich Consulting Group, Albuquerque, New Mexico

8:30 – 9:20 **Opening Panel: Digging Out of Your Underfunded Status**

- How should you approach it?
- Looking at new and novel approaches to investing
- What are managers using to try to generate larger returns?
- Looking beyond plain vanilla stuff - - what is available and how much can I commit?
- Aggressive vs. passive approaches: how much more are you willing to risk?

John S. Shanklin, CFA, CAIA, *Senior Consultant*
NEPC, Las Vegas, Nevada

Russ Kamp, *Managing Partner*
Kamp Consulting Solutions, LLC, Midland Park, New Jersey

Chris Kasmer, *Business Agent/Organizer*
Chicago Regional Council of Carpenters, **Local 1027**, *Trustee (Chairman)*, **Chicago Transit Authority Retiree Health Trust**
Alternate Trustee, **Chicago Transit Authority Retirement Plan**, Chicago, Illinois

9:30 – 10:30 **Creating a Defensive Portfolio: Learning to Balance Downside Risk Against Upside Potential**

- Incorporating defensive measures for the possibility of a market correction
- How can you prepare your fund for a market shift?
- How much risk should your pension take?
- When do you say "enough"?
- Finding the right balance for your fund's objectives/ priorities
- Zeroing in on high forecasted returns
- Unintended consequence

Jeffrey Kowalczyk, *Senior Investment Consultant*
Lowery Asset Consulting, LLC, Chicago, Illinois

John Ulrich, *President*
Ulrich Consulting Group, Albuquerque, New Mexico

Charlie Waibel CFA, *Managing Director*
Sellwood Consulting LLC, Portland, Oregon
Plan, Chicago, Illinois

Track "B"
Health & Wellness Benefits

8:20 – 8:30 **Co-Chairs' Opening Remarks:**

John Everson, *Fund Administrator*
SDC-League Health Fund, New York, New York

TBA

8:30 – 9:20 **Preparing for the Realities of the Cadillac Tax: How Will It Play Out?**

- What is the status of the Cadillac tax?
- What are the caps for employers?
- Is there any relief in sight?
- How is the Cadillac Tax impacting multiemployer plans?
- Will FSAs help?

Cathy Sanderson, *Fund Administrator*
UFCW Union Local 655 Welfare Fund, Manchester, Missouri

David De La Torre, *Secretary Treasurer*
Laborers' Local 261, San Francisco, California

Ruth Donahue, *Vice President and Consultant*
Segal Consulting, Chicago, Illinois

"Excellent! Conference addressed current issues/ trends facing plans"

Joe Bakes, **Teamsters 705**

9:20 – 9:30 *Transition Time*

9:30 – 10:30 **Looking at Cost-Containment Programs That Actually Work**

- Monitoring end-stage renal usage claims to ensure you are only paying for what you are responsible for
- Monitoring kidney transplant claims
- Duplicate claim payments
- Emergency room usage when other insurance is involved
- Once-in-a-lifetime claims
- Innovative ideas to lower emergency department use to urgent care centers or primary care physicians

Tom Lamb, *Administrator*
Law Enforcement Health Benefits, Inc., Philadelphia, Pennsylvania

"Good education on all of the current topics for pension trustees"

Bart Carrigan, **AGC of Michigan**

10:30 – 10:45 *Morning Break sponsored by* BlueCross BlueShield Association

10:45 – 11:30 **Measuring Your Performance Against Your Own Risk and Return Objectives**

- How do you judge your performance? Example 7.5% return target with a 10% volatility; beat the universe median; beat a blended index benchmark
- How do investors hurt themselves, and what can you do to avoid harmful but attractive decisions?
- Avoiding performance that results in value destruction

Gary A. Amelio, *Chief Executive Officer*
San Bernardino County Employees' Retirement Association, San Bernardino, California

Jeffrey Kowalczyk, *Senior Investment Consultant*
Lowery Asset Consulting, LLC, Chicago, Illinois

Herbert Nishii, *Senior Consulting Associate*, **Verus (Formerly Wurts & Associates)**, El Segundo, California

11:30 – 12:15 **What Comes First, the Actuarial Assumption or the Investment Allocation?**

In today's multiemployer environment, investment return has become an increasingly important aspect of plan funding. But, not all investment strategies have kept up with the times, and simple communication between your actuary and investment consultant could go a long way in helping achieve your plans' optimal solution. In this session, an investment consultant and an actuary will conduct a dialogue over how they can work together on multiemployer retirement plans. Among the key questions that will be addressed:

- What factors go into asset allocation?
- How and when should plans adapt, considering these factors?
- How has the market affected actuarial assumptions in recent years?
- What are the dangers of overreacting to either a great or a bad rate of return, both from an investment and an actuarial point of view?

Richard Dahab, *Chairman*
Dahab Associates, Inc., Bayshore, New York

Glenn Ezard, *Senior ConsultantSegal*
Rogerscasey, Los Angeles, Calliforina

Phillip A. Romello, *Senior Vice President and Actuary*
Segal Consulting, Washington DC

10:45 – 11:30 **Case Study: Disease Management From A to Z**

- Innovative ways of engaging members
- Early identification early intervention
- Educating members that it's their money, not the insurers'
- Providing resources to union fund employees to educate members
- Ensuring discharge planning is coordinated
- Innovative member contacts to increase wellness-education fund programs
- How to identify chronically ill members and action items you can take to help

Samuel J. Kenish, CEBS, *Administrator*
Teamsters Local 830 Employee Benefit Funds, Philadelphia, Pennsylvania

Steven Villella, *Managing Director*
Touchstone Consulting Group, Inc., Worcester, Massachusetts

11:30 – 12:15 **Wellness Cost, Screening, Incentives and So Much More**

- Health screening cost and results
- Monitoring and ensuring compliance with CPAP users
- Monitoring and ensuring compliance with diabetics and asthmatics
- Innovative ways to contact and educate members on your fund's wellness and disease management
- Designing health screenings and health fairs based on medical claims
- What types of incentives work?

Tom Lamb, *Administrator*
Law Enforcement Health Benefits, Inc., Philadelphia, Pennsylvania

Chris Kasmer, *Business Agent/Organizer*
Chicago Regional Council of Carpenters, **Local 1027,** *Trustee (Chairman)*, **Chicago Transit Authority Retiree Health Trus,** *Alternate Trustee*, **Chicago Transit Authority Retirement Plan**, Chicago, Illinois

"Tons of information to digest"

Tony Gazzaniga, **IUEC 18**

12:15 – 1:30 *Luncheon sponsored by* Hamilton Lane

1:30 –2:15 **Private Equity Investing: What Should You Expect for 2016?**

- Why private equity in the current market environment?
- Should you allocate to private equity? How much is appropriate?
- How has the industry evolved?
- Common misconceptions about private equity

Emilly Nomeir, *Vice President*
Hamilton Lane, Bala Cynwyd, Pennsylvania

Richard Dahab, *Chairman*
Dahab Associates, Inc., Bayshore, New York

"Very good location, attendance, and core presentations"

1:30 –2:15 **Evaluating the ROI of Disease Management and Wellness Programs**

- How to evaluate the ROI of disease management and wellness programs
- How can you effectively measure the short and long term effects?
- Is the cost, time, and resources worth the investment?
- Projections and appropriate adjustments

Sally Reppucci, *Executive Vice President - Operations and Technology*
Renalogic, Sandpoint, Idaho

Steven Villella, *Managing Director*
Touchstone Consulting Group, Inc., Worcester, Massachusetts

2:15-3:00 **Hedge Funds and Taft-Hartley Plans: Value, Risk, Fees, and Returns**

- How much value have hedge funds added to your portfolio?
- Reducing fees
- Manager and transparency expectations
- Which hedge fund strategies are available and which are right for your fund?

Dave Russell, CFA, *IPS Senior Investment Strategist*
Investment Performance Services, LLC
Newtown, Pennsylvania

John Ulrich, *President*
Ulrich Consulting Group, Albuquerque, New Mexico

2:15-3:00 **Managing Prescription Drug Costs and Potential Abuses**

- What is driving the cost of prescriptions?
- Conducting your own prescription audit
- Designer vs. generic pros and cons
- Looking for alternative ways to treat various ailments
- How can plans spot pain medication abuse and what can you do about it once you've detected it?
- Controlling compound prescription drugs
- Examining the dramatic increases in generic prescription costs

Cathy Sanderson, *Fund Administrator*
UFCW Union Local 655 Welfare Fund,
Manchester, Missouri

Maurice "Mo" Hodos, *Fund Administrator*, **UFCW National Health and Welfare Fund**, Englewood, New Jersey

3:00-3:30 *Afternoon Break sponsored by* SYMETRA

3:30 – 4:15 **Low Volatility Equity: Can You Have Your Cake and Eat it Too?**

- What types of returns can you expect?
- Side by side comparison of various equity options
- Risk tolerances

John S. Shanklin, CFA, CAIA, *Senior Consultant*
NEPC, Las Vegas, Nevada

Charlie Waibel CFA, *Managing Director*
Sellwood Consulting LLC, Portland, Oregon

3:30 – 4:15 **Specialty Drugs and How To Manage Them**

- How do you determine who gets these incredibly expensive new drugs?
- How can you manage them so plans don't go broke?
- When is stop-loss insurance a good choice for your fund?
- What is bio-ethics and how does it work?

John R. Adler, *President*
Adler Rx Consulting, LLC, West Bend, Wisconsin

Mostafa Kamal, *Chief Executive Officer*
Magellan Rx Management, Scottsdale, Arizona

4:15-5:15 **Cocktail Reception Immediately Following Sponsored by:**

Contact Jennifer Clemence for more information on our sponsorship opportunities at jclemence@frallc.com or 704-341-2438

"Great presentations – people presenting are actually living the work – very helpful and great networking"

Cheryl Strange, **SEIU Healthcare NW Health Benefit Trust**

DAY THREE: TUESDAY, JANUARY 26, 2016

ROUNDTABLES ARE ELIGIBLE FOR 2 TICKETS

8:00 – 9:15 **Morning Continental Breakfast**

Breakfast Roundtable:

A bell will ring four times within this 75 minute session to give attendees a chance to listen to four or more topics. The moderator will rotate tables after every 15-20 minutes so you will be able to "sit in" on four different sessions either on the investment/pension side or the health & welfare side.

Roundtable A: **Group Benefits and Medical Stop Loss Solutions for Taft-Hartley, Union and Public Sector Groups**

Thomas Bittner, *Regional Vice President,* **Symetra Life Insurance Company**, Bellevue, Washington

Tom Costello, *Vice President, Stop Loss Sales*, **Symetra Life Insurance Company**, Bellevue, Washington

Roundtable B: **Topic & Speaker TBA**

Roundtable C: **Topic & Speaker TBA**

Roundtable D: **Topic & Speaker TBA**

FOR MORE INFORMATION ABOUT PRESENTING ON THE BREAKFAST ROUNDTABLES PLEASE CONTACT JENNIFER CLEMENCE AT 704-341-2438 OR JCLEMENCE@FRALLC.COM

Track "A"
Pension & Annuity Topics

9:15 – 10:00 **Outsourcing CIOs: No Such Thing as Auto-Pilot Mode - - Actively Monitoring Your Portfolio**

- The realities of outsourcing CIOs
- Cost vs. benefit
- Liabilities and responsibilities
- What can you do to actively monitor your portfolio and consultant?
- Looking at the various levels of outsourcing available

Dave Russell, CFA, *IPS Senior Investment Strategist*
Investment Performance Services, LLC
Newtown, Pennsylvania

Bill O'Donnell, *Senior Consultant*
Alan Biller & Associates, Menlo Park, California

Jeff Benoit, *Director of Taft-Hartley Services*
Dimeo Schneider and Associates, Chicago, Illinois

PJ Kelly, *Partner*
Hewitt EnnisKnupp, Inc., Chicago, Illinois

10:10 – 10:50 **Aligning Social and Investment Objectives: Working Toward Economic Stimulation and Job Creation through Impact Investing**

- What is the difference between ESG, SRI, and Impact investing?
- Where do you begin and how do you source investments?
- Integrating social and investment objectives
- Are you unintentionally supporting investment that are hurting your long term goals?
- Size and growth of the market
- Does ESG/SRI/Impact investing represent smarter investments by risk?
- How do the returns compare to traditional strategies?

Emily E. Johnstone, *Managing Director*
AFL-CIO Housing Investment Trust

Michael D. Underhill, *Chief Investment Officer*
Capital Innovations, LLC, Pewaukee, Wisconsin

Jeffrey Pettiford, *Managing Member, Investor Relations,*
Window Rock Capital Partners, LLC, Chicago, Illinois

11:05 – 11:50 **Global Market Conditions and Concerns**

- Looking at global market conditions and their effects on your investments/portfolio
- Geo-economic concerns
- Understanding the effects of Greece and other European markets
- Scrutinizing the strength of the U.S. dollar
- Japan abenomics updates
- The growth in China and what it means for global markets or emerging markets

Track "B"
Health & Welfare Topics

9:15 – 10:00 **MIA's Legendary Administrators' Roundtable**

Back by popular demand, our Administrators' Roundtable has become a staple at all MIA events. This is your chance to hear our panel of experienced Administrators discuss their everyday challenges in an interactive and informal setting. Audience participation is strongly encouraged!

- Conducting your own prescription audit
- Plan design
- Cost constraints
- Communication and training revolutions
- Negotiations
- Employee surveys
- Reporting requirements and penalties
- Health claims
- Specialty drugs
- Compound games cost
- Improving member engagement
- And so much more

John Everson, *Fund Administrator*
SDC-League Health Fund, New York, New York

Maurice "Mo" Hodos, *Fund Administrator*, **UFCW National Health and Welfare Fund**, Englewood, New Jersey

10:00 – 10:10 *Transition Time*

10:10 – 10:50 **NCCMP Speaks Out: Taking a Close Look at the Latest Legal and Regulatory Update**

- What are the latest regulatory updates/changes?
- How will these changes impact multi-employer plans?
- New relief in sight?
- Predictions and policy updates

Randy DeFrehn, *Executive Director*
National Coordinating Committee For Multiemployer Plans, Washington DC

"Excellent speakers and topics were covered"

Maurice Hodos, **UFCW National Health & Welfare Fund**

11:50-11:05 *Morning Break sponsored by Intercontinental logo & Hotel Check-Out*

11:05 – 11:50 **Mental Health Cost and Treatment for Addiction: What is the Impact on Your Fund?**

- Brief overview of addiction
- Are these relevant concerns for members and fund administrators?
- Educating members and supervisors as to the warning signs
- Early intervention
- Medically sponsored addiction – over use / abuse of medically prescribed analgesic medications

- Taking a snapshot of current global issues
- What are the BRICS and how will they affect the economy?

Ed Omata, *Senior Vice President*
Meketa Investment Group, Inc., Carlsbad, California

Jeff Benoit, *Director of Taft-Hartley Services*
Dimeo Schneider and Associates, Chicago, Illinois

Kelley Stillwell, *CEO*
Retired Union Workers, Henderson, Nevada

11:50 – 12:30 **Real Estate Gems and Over-Exposed Investments**

- Over-exposed and under exposed real estate opportunities: where should investors turn?
- Short and long term returns
- Addressing liquidity concerns
- Spotting valuation discrepancies
- Avoiding valuation conflicts
- Ensuring the proper amount of diversification through real estate
- Chasing winning real estate investments

Peter Palandjian, *Chairman & CEO*
Intercontinental Real Estate Corporation, Boston, Massachusetts

- Legal considerations / job retention
- Most appropriate treatment centers for patient discharge, planning, and compliance
- Relapse prevention

Paul M. DiKun, CAC, Ed.D, Ph.D., **Licensed Psychologist**
Law Enforcement Health Benefits, Inc., Philadelphia, Pennsylvania

11:50 – 12:30 **The Future of Tele-Health/Medicine**

- How is healthcare evolving and what can you expect in the future?
- How will it help your members/fund?
- Taking a look at various providers in the industry
- How will prescriptions work?
- ROI of tele-medicine
- What do the early results indicate?

Dan Doyle, *Executive Director, Public and Labor*
Teladoc, St. Petersburg, Florida

Richard L. Snyder, M.D., *Senior Vice President and Chief Medical Officer*
Independence Blue Cross, Philadelphia, Pennsylvania

12:30 – 1:45 *Luncheon for All MIA Attendees*

1:45 – 2:30 **Diversifying Assets: Next Generation Fixed Income Strategies**

- Traditional fixed income vs. next generation investments – how do they compare?
- What type of non-traditional fixed income investments are available and how do they work?
- How rising interest rates impact returns and what can you do about it?
- Are you prepared for the long term effects of bonds value dropping?
- Looking at other non-equity driven strategies

Herbert Nishii, *Senior Consulting Associate*, **Verus** (Formerly **Wurts & Associates**), El Segundo, California

2:30 – 3:15 **Dispelling Rumors and Calming fears for an Insolvent Fund and Lower Hours**

- Coping with communications and ramifications of insolvencies
- Communicating with a failing plan
- Conveying bad news
- Recruiting members moving forward
- Dispelling rumors and calming fears
- Social media nuances and opportunities
- Construction trends
- Technology help and hindrances
- Short and long term projections
- Actual bookable hours

Danny Caliendo, *Senior Instructor/Founder*
Labor Rising Group, Chicago, Illinois

PJ Kelly, *Partner*
Hewitt EnnisKnupp, Inc., Chicago, Illinois

Dan Woodman, *Founder*
Leading Labor, Washington D.C.

1:45 – 2:30 **The Heroin Epidemic and Your Benefit Plan**

- How Federal legislation and addiction trends combined to create a "perfect storm" for benefit plans
- Predatory Treatment Programs
- Steps you can take to protect your plan assets

Anthony Rizzuto, *Founder and Executive Director*
Families In Support of Treatment, Westhampton Beach, New York

"Very informative"

Frank Cognetta, **UFCW Local 1D**

2:30 – 3:15 **Topic to be Announced**

"Great speakers – they get better each year…"

John Everson, **SCD League Health Fund**

"Speakers and information was current and valuable"

Eric Mueller, **Heartland Health & Wellness Fund**

"Great Speakers and topics – great networking and good food"

Andy Johnson, **Teamsters Center Services**

3:15 *End of MIA 2016*
(Submit Evaluation Forms)

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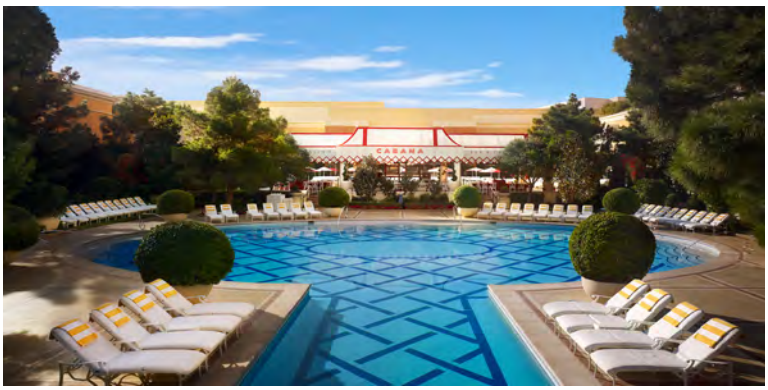

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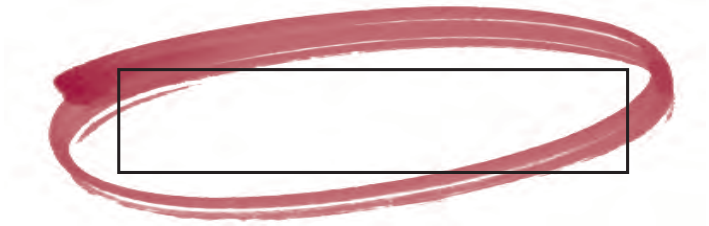

FINANCIAL RESEARCH ASSOCIATES
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LACERA

October 16, 2015

TO: Each Member
Board of Retirement

FROM: Ricki Contreras, Manager
Disability Retirement Services Division

FOR: November 4, 2015 Board of Retirement Meeting

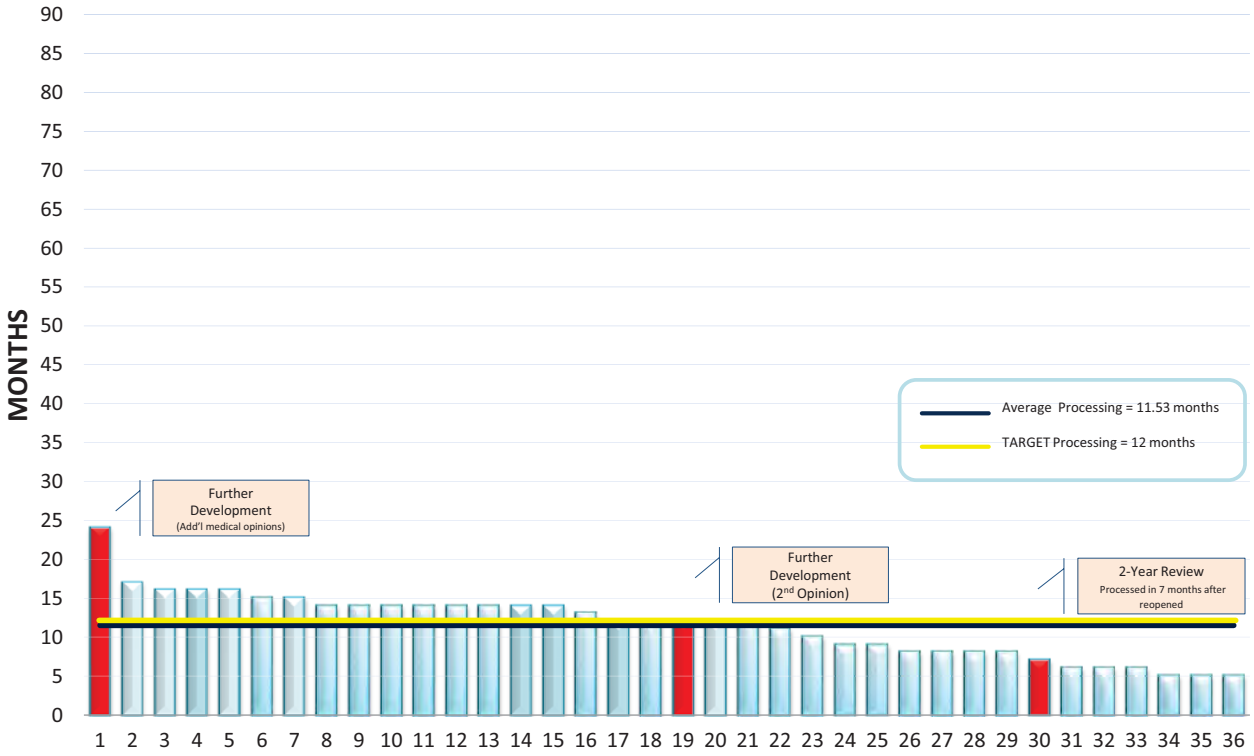
SUBJECT: **Application Processing Time Snapshot Reports**

At the February 4, 2015 meeting, the Disability Procedures & Services Committee voted to add two additional snapshot reports addressing application processing times and pending applications by elapsed time since application date. These reports will now be provided on a monthly basis along with the current snapshot that provides a look at application processing time before and after procedural changes were made to the disability application process. The Board adopted proposed changes on July 12, 2012. The chart breaks down the periods for cases processed under the old procedures vs. the new procedures with the associated monthly processing timeframes.

The following chart shows the total time from receipt of the application to the first Board action for the month in question.

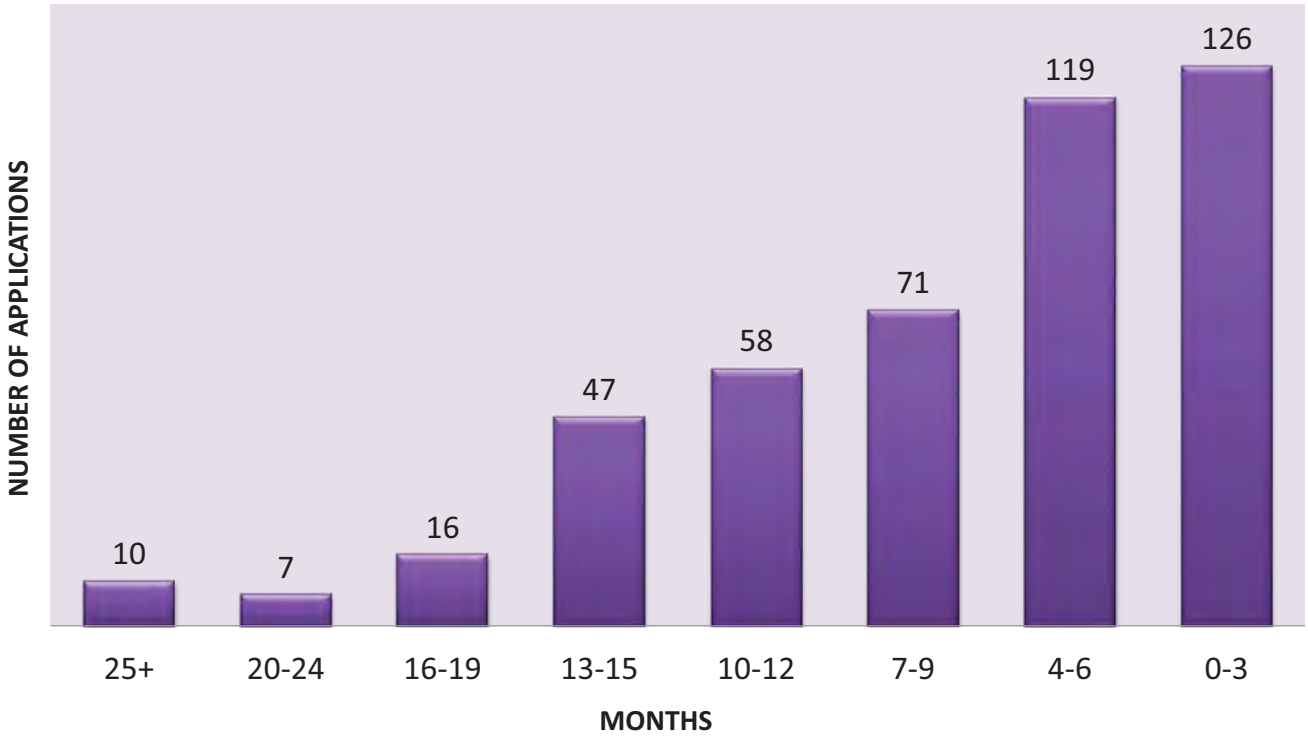
Consent & Non-Consent Calendar			
Received Prior to July 12, 2012		**Received After July 12, 2012**	
Number of Applications	**Processing Time (in Months)**	**Number of Applications**	**Processing Time (in Months)**
0	0	33	11.27
Revised/Held Over Calendar			
2-Year Review (1 case, total processing time since reopened)		7.0	
Held Over/Revised; Returned for Further Development (2 Cases, total average processing time since receipt of application)		Case 1 24	Case 2 12
Average Processing Time for Revised/Held Over Calendar		14.33	

ACTUAL vs. AVERAGE PROCESSING TIME



November 4, 2015 AGENDA

TIME ELAPSED FOR PENDING APPLICATIONS



LACERA

October 22, 2015

TO: Each Member
Board of Retirement

FROM: Disability Procedures and Services Committee
Vivian H. Gray, Chair
William de la Garza, Vice Chair
William R. Pryor
Les Robbins
Yves Chery, Alternate

FOR: November 4, 2015, Board of Retirement Meeting

SUBJECT: **Proposed Updated Policy Statement: Hiring of Panel Physicians: Qualifications, Licensing, Certification and Insurance Requirements for Board Appointed Panel Physicians**

RECOMMENDATION

Approve the Proposed Updated **"Policy Statement: Hiring of Panel Physicians: Qualifications, Licensing, Certification and Insurance Requirements for Board Appointed Panel Physicians".**

BACKGROUND

On July 1, 2015, staff informed the Committee that a LACERA Board appointed panel physician's certification had lapsed as of January 1, 2014. Staff also provided a summary of the immediate actions taken following notification of the certification lapse. The panel physician was informed that he was suspended from the panel, all pending medical appointments were canceled and members were rescheduled with other physicians, and any outstanding medical reports were completed and returned to LACERA.

DISCUSSION

Because of the certification lapse, staff began an audit of its existing policy and procedures to identify gaps in the process that may have caused us to overlook the above referenced certification lapse. Staff found that the Board's current policy did not

address ongoing certification requirements, auditing practices, or LACERA's contractual agreement with its physicians. In an effort to prevent any future oversight, staff has prepared a proposed updated policy, which includes new auditing procedures.

On October 7, 2015, the Disability Procedures and Services Committee reviewed, edited and approved the proposed policy for final adoption by the Board of Retirement.

Update Existing Policy

The Board of Retirement's existing policy is limited and simply states that LACERA will hire only board certified[1] physicians to its panel; however, the policy is silent concerning what would happen should a panel physician's certification lapse (Attachment 1). Staff also found there were no written procedures outlining the process for verifying licensing and certification. The Division's current practice is to verify medical licensing and certification when LACERA and the physician first enter into a contract[2.] Medical licensing is checked annually while board certification is not routinely checked following appointment to the Board's of Panel of Examining Physicians.

To address this issue, staff is presenting the attached proposed updated policy statement to establish the Board of Retirement's hiring, licensing, certification, and insurance requirements. Staff has developed written procedures to implement the new policy. The policy ensures frequent monitoring of panel physician licensing, certification, and insurance coverage requirements.

Auditing Procedures

The Division's existing audit procedures for verifying physician licensing, certification, and insurance coverage is almost nonexistent. Each physician had a separate paper file that housed some of the information, but it was not as up to date as required to monitor expiration dates effectively. To address this issue, staff contacted all panel physicians and requested documentation of medical licensing, board certification, and insurance coverage. A database was created to maintain a record of all expiration dates so that staff can monitor the information on an ongoing basis. Staff sent a written follow-up request and placed the 4 (four) physicians who have not responded on suspension until proper documentation has been received. There has been no impact in our ability to service our members.

---

1 Board certification refers to a member of the American Board of Medical Specialties, a specialty board with the Accreditation Council for Graduate Medical Education accredited postgraduate training program, or a specialty board approved by the Medical Board of California's Licensing Program or equivalent.

2 Prior to 1990, recertification was not required; physicians were certified for a lifetime, subsequently physicians were required to recertify every 10 years.

Contracts Review

Panel physician contracts are in the process of being reviewed by the Legal Office for compliance with the proposed updated policy including consequences for failing to maintain the terms of the agreement.

IT IS THEREFORE RECOMMENDED THAT the Board of Retirement approve the Proposed Updated **"Policy Statement: Hiring of Panel Physicians: Qualifications, Licensing, Certification and Insurance Requirements for Board Appointed Panel Physicians"**

Attachment

TLC:RC

Noted and Approved:

JJ Popowich, Assistant Executive Officer

Date: 10/23/15

LACERA POLICY STATEMENT

HIRING OF PANEL PHYSICIANS: QUALIFICATIONS, LICENSING, CERTIFICATION, AND INSURANCE REQUIREMENTS FOR BOARD APPOINTED PANEL PHYSICIANS

(Effective November 4, 2015)

Purpose

The purpose of this policy is to establish the governance concerning the qualifications, hiring, licensing, certification and insurance requirements for all Board Appointed Panel Physicians ("Physician(s)") and to clearly define the auditing mechanism to ensure that all requirements are maintained throughout the life of the contractual relationship with the physicians. This policy will also establish actions in the event a Physician is unable to maintain the Board required licensing, certification, or insurance coverage.

I. Statement of Policy

The Board of Retirement requires all Physicians, wishing to be appointed to the Board of Retirement's Panel of Physicians, to hold and maintain a valid California medical license, board certification when available within a specialty, and medical malpractice insurance coverage.

Medical License

All Physicians shall, at all times during the term of their contractual agreement with LACERA, maintain a valid medical license issued by the State of California Medical Board and shall maintain a medical record free of significant disciplinary actions, malpractice judgments/settlements, and criminal charges.

Board Certification

All Physicians shall, at all times during the term of their contractual agreement with LACERA, be a member of the American Board of Medical Specialties, a specialty board with the Accreditation Council for Graduate Medical Education accredited postgraduate training program, or a specialty board approved by the Medical Board of California's Licensing Program or its equivalent when available within a specialty.

Insurance Coverage

All Physicians shall, at all times during the term of their contractual agreement with LACERA, maintain insurance coverage and limits as specified in the individual contract. Physicians will provide LACERA with proof of such insurance coverage upon entering into a contract and annually thereafter.

Physician Requirements Regarding Reporting of Lapses and Resulting Penalties for Non-Compliance

All Physicians shall immediately notify LACERA if any license, certification, or insurance coverage is lapsed, suspended, or revoked, or if any proceeding or investigation is commenced by an agency relating to the Physician's license or certification.

In the event a Physician no longer meets the Board of Retirement's requirements as outlined above the Physician's contract with LACERA will be immediately suspended. Notification to the panel physician will be sent via certified mail.

All Physicians will be required to respond within 30 business days upon any LACERA inquiry regarding licensing, certification, or insurance coverage, or any reports of an investigation. Failure to respond shall result in the Physician's contract with LACERA to be suspended. Any inquiry will be made in writing to the panel physician and will be sent via certified mail.

Physicians in non-compliance who correct the non-compliance issue, shall be allowed to request an expedited reinstatement review by the Board of Retirement.

Disability Retirement Services Physician Compliance Audit Procedures

Upon entering a contractual agreement with LACERA, all Physicians shall supply staff with proof of licensing, certification, and insurance coverage as set forth in this policy. Staff shall maintain a record of all expiration dates and conduct quarterly audits to ensure that all licensing, certification, and insurance coverage are current. If a Physician is unable to provide proof upon request within 30 business days of the request, the Physician will be suspended until all policy requirements are met.

DISABILITY RETIREMENT SERVICES

The Board grants staff the authority to suspend services of any Physician that is suspected of violating this policy. Staff shall commence a preliminary inquiry to confirm the validity of the violation. Staff shall notify the Board of any lapses, suspensions, revocations, or any proceedings/investigations commenced by a licensing or certifying agency at the next available Board of Retirement meeting.

BOARD OF RETIREMENT

The Board may place a Physician on temporary probation or rescind any contractual agreement upon notification of a violation of this policy. The Board reserves the right to reinstate a Physician once a violation has been corrected to its satisfaction. Physicians will undergo an expedited reinstatement process, applications for reinstatement will be submitted directly to the Board of Retirement.

II. Implementation

The policy is established pursuant to the Board of Retirement's fiduciary responsibility to prudently administer the retirement plan in accordance with the County Employees Retirement Law of 1937, and replaces the previous policy titled "Hiring of Panel Physicians". This policy may be modified in the future by Board of Retirement action.

Adopted: _____

LACERA

October 22, 2015

TO: Board of Retirement
Each Member

FROM: Insurance, Benefits and Legislative Committee
Les Robbins, Chair Sent for Les Robbins
Alan Bernstein, Vice Chair
William de la Garza
Vivian H. Gray
Ronald Okum, Alternate

FOR: November 4, 2015 Board of Retirement Meeting

SUBJECT: **ADOPT VOTING INSTRUCTIONS ON SACRS 2016 LEGISLATIVE PROPOSALS**

RECOMMENDATION

That the Board of Retirement direct its voting delegate to support inclusion of the following in the SACRS 2016 legislative platform:

A. District Status for 1937 Act County Employees Retirement Systems (SACRS #1)—To provide retirement systems the option to adopt district status.

B. Optional Employee Sworn Statements (San Diego #1)—To allow the retirement system to collect the member's enrollment information directly from the employer in lieu of a sworn statement from the member.

DISCUSSION

Each year the 20 counties operating under the County Employees Retirement Law of 1937 (CERL) are asked to submit proposals to the State Association of County Retirement Systems (SACRS) Legislative Committee for inclusion in the SACRS legislative platform. The items submitted should have application to all CERL systems rather than an individual system; they should not propose new benefits that will be paid for by the plan sponsor; and they should not create major issues, such as conflicts with Proposition 162 or with any of the 19 other CERL systems.

The following two items were approved by the SACRS Legislative Committee for inclusion in the SACRS 2016 legislative platform. The proposals will be presented to the SACRS membership and voted on at the November 2015 SACRS Conference.

Staff recommends that a "Yes" vote be cast on the following proposals for inclusion in the SACRS 2016 legislative platform.

A. District Status for 1937 Act County Employees Retirement Systems

SACRS #1—This proposal would provide the board of retirement of any 1937 Act county the option to make an election for the retirement system to become a district. Currently, the Orange County, San Bernardino County, Contra Costa County, and, most recently, Ventura County systems are independent districts.

The proponents of this proposal assert: District status would enable retirement systems located in counties that do not currently recognize the system's compensation setting authority to directly recruit top-level and senior management personnel. As employees of the retirement system rather than the county, these personnel would have more independence to enforce the anti-spiking provisions of the California Public Employee's Pension Reform Act of 2013 (PEPRA). It would allow the retirement system to offer compensation competitive with the private sector to attract and retain such personnel. All other personnel not designated as employees of the district will be employees of the county.

While this proposal if enacted into law would cover LACERA, the County of Los Angeles already recognizes that LACERA has independent authority to set compensation for its employees, with such compensation incorporated into the County's compensation ordinance under CERL as it currently reads.

There is no specific language proposed as of this date. Specific language for the proposal will be developed by the SACRS Legislative Committee.

Recommendation: Vote YES

B. Optional Employee Sworn Statements

San Diego #1—The board of retirement regulations require that a sworn statement be completed by every person who becomes a member of the retirement system. The sworn statement collects information such as date of birth, nature of employment with the county, and other personal information.

The proponents of this proposal assert: If members are automatically enrolled in a retirement plan, and the member's enrollment information is collected and transmitted by the employer, then the filing of a sworn statement may be duplicative and unnecessary. The proposal seeks to allow information to be provided by the employer in lieu of the sworn statement being filed by the member.

The proposed language is in the attachment.

Recommendation: Vote YES

IT IS THEREFORE RECOMMENDED THAT YOUR BOARD direct its voting delegate to support inclusion of the following in the SACRS 2016 legislative platform:

A. District Status for 1937 Act County Employees Retirement Systems (SACRS #1)—To provide retirement systems the option to adopt district status.

B. Optional Employee Sworn Statements (San Diego #1)—To allow the retirement system to collect the member's enrollment information directly from the employer in lieu of a sworn statement from the member.

Attachments

2015. Leg.SACRS 2016 Legislation.BOR.102215

YEAR 2016 SACRS LEGISLATIVE PLATFORM WORKSHEET

PLEASE COMPLETE AND RETURN BY SEPTEMBER 4, 2015

Title of Issue: 1937 Act County District Status Authorization

Association: SACRS Board of Directors

Contact Person: Jim Lites

Phone #: 916 266-4575

Fax #: 916 266-4580

Email: jlites@calstrat.com

Please answer the following questions as fully as possible:

1. Description of issue.

   District authorization essentially allows a county retirement system to hire key executive personnel as employees of the retirement system, rather than employees of the county. Orange, San Bernardino and Contra Costa already operate under this section of the County Employees Retirement Law of 1937. The Ventura County Employees Retirement System sponsored AB 1291/Ch. 223, Statutes of 2015, which provides a modified version of district status for Ventura.

   With the enactment of the Public Employee Pension Reform Act of 2012 (PEPRA), one of the responsibilities PEPRA mandates upon boards of retirement is the requirement to monitor and enforce the anti-spiking provisions of the measure. With senior retirement system personnel as employees of the retirement system rather than the county, 1937 systems will have greater independence to fulfill the PEPRA anti-spiking provisions. In addition, it will assist our local retirement system in attracting and retaining highly-talented human capital necessary to effectively manage a retirement system and an investment portfolio in today's investment marketplace.

2. Recommended solution.

   Provide statutory authorization for the Board of Retirement for any 1937 act system to make an election to become an independent district.

3. Specific language that you would like changed in, or added to, '37 Act Law, and suggested code section numbers.

   The intent is to amend Government Code Sections 31468 and 31522.5 to allow each 1937 Act county retirement system to elect to have district status. The specific language will be written based on the guidance of the SACRS Legislative Committee.

4. Why should the proposed legislation be sponsored by SACRS rather than by your individual retirement association?

   This proposal would provide the remaining 1937 Act county retirement systems with the authority to become a district. The requested revisions will affect all CERL systems that have not yet sought legislation to obtain district status.

5. Do you anticipate that the proposed legislation would create any major problems, such as conflicting with Proposition 162 or create a problem with any of the other 19 SACRS retirement associations?

   The intent of this proposal is to provide county-optional authority.

6. Who will support or oppose this proposed change in the law?

   SACRS would seek support from other 1937 Act stakeholders.

7. Who will be available from your association to testify before the Legislature?

   Richard Stensrud, Chair, SACRS Legislative Committee.

E-mail or mail your legislative proposals to:

Jim Lites
California Strategies, LLC
980 9th Street, Suite 2000
Sacramento, CA 95814
Phone: (916) 266-4575
Email: jlites@calstrat.com

YEAR 2016 SACRS LEGISLATIVE PLATFORM WORKSHEET

PLEASE COMPLETE AND RETURN BY SEPTEMBER 4, 2015

Title of Issue: Sworn Statement Requirement

Association: San Diego County Employees Retirement Association (SDCERA)

Contact Person: Johanna Shick, Chief Service Officer
Elaine Reagan, Chief Legal Officer

Phone #: 619.515.6815
619.515.6804

Fax #: 619.515.5071
619.515.5067

Please answer the following questions as fully as possible:

1. Description of issue.

   Government Code §31526 states "The regulations shall include provisions: (a) For the election of officers, their terms, meetings, and all other matters relating to the administrative procedure of the board. (b) For the filing of a sworn statement by every person who is or becomes a member, showing date of birth, nature and duration of employment with the county, compensation received, and such other information as is required by the board. (c) For forms of annuity certificates and for such other forms as are required."

   Some retirement systems receive date of birth, nature and duration of employment with the county and compensation automatically via electronic payroll feed from the County. At the time the statute became effective in 1947 electronic payroll feeds did not exist, making the collection of this information critical for enrolling members into the system.

   When counties automatically enroll eligible employees into the retirement system, and collect and report to the retirement system the required information, the requirement of collecting a sworn statement from each eligible employee is duplicative and unnecessary. Further, requiring the collection of a sworn statement from each eligible employee creates compliance issues and inefficiencies. Because not all employees return their sworn statements, additional staff time and resources must be expended to obtain the form from employees in order to comply with Government Code §31526; however, the retirement system already has the necessary information from the employer via the payroll feed.

2. Recommended solution.

   Add language that would allow counties to collect members' date of birth, nature and duration of employment with the county, and compensation received from the employer in lieu of requiring the member to complete a sworn statement. This would enable those counties that have implemented procedures to automatically enroll eligible employees into the retirement system, and collect and report the required information to the retirement system automatically to streamline processes, thus making the administration of the benefit more efficient and bringing statute in alignment with modern-day technology.

3. Specific language that you would like changed in, or added to, '37 Act Law, and suggested code section numbers.

   §31526: The regulations shall include provisions: (a) For the election of officers, their terms, meetings, and all other matters relating to the administrative procedure of the board. (b) For the filing of a sworn statement by every person who is or becomes a member, showing date of birth, nature and duration of employment with the county, compensation received, and such other information as is required by the board or, alternatively and in lieu of a sworn statement, for such information to be provided by the member's employer to the retirement association in a form to be determined by the retirement association. (c) For forms of annuity certificates and for such other forms as are required.

4. Why should the proposed legislation be sponsored by SACRS rather than by your individual retirement association?

   The requested addition to Government Code §31526 affects all CERL systems, not only SDCERA.

5. Do you anticipate that the proposed legislation would create any major problems, such as conflicting with Proposition 162 or create a problem with any of the other 19 SACRS retirement associations?

   No

6. Who will support or oppose this proposed change in the law?

   The proposed amendment is unlikely to raise opposition as it is designed to allow the status quo for those systems that prefer it. It does not prohibit systems from continuing to use sworn statements; it simply allows those systems gathering this information electronically to streamline their processes and more reliably collect the information.

7. Who will be available from your association to testify before the Legislature?

   Johanna Shick, Chief Service Officer
   Elaine Reagan, Chief Legal Officer

E-mail or mail your legislative proposals to:

Jim Lites
California Strategies, LLC
980 9th Street, Suite 2000
Sacramento, CA 95814
Phone: (916) 266-4575
Email: jlites@calstrat.com

LACERA

October 22, 2015

TO: Board of Retirement
Each Member

FROM: Insurance, Benefits and Legislative Committee
Les Robbins, Chair SWL for Les Robbins
Alan Bernstein, Vice Chair
William de la Garza
Vivian H. Gray
Ronald Okum, Alternate

FOR: November 4, 2015 Board of Retirement Meeting

SUBJECT: **LACERA 2016 Legislation**

RECOMMENDATION

That the Board of Retirement direct staff to work with LACERA's legislative advocate and seek an author to introduce legislation to amend the definition of Plan D in the Prospective Plan Transfer provisions of the County Employees Retirement Law of 1937.

BACKGROUND

The California Public Employees' Pension Reform Act of 2013 (PEPRA) became effective on January 1, 2013. PEPRA required new retirement plans to be applicable to individuals who became new members of a public retirement system on or after January 1, 2013. In compliance with the requirements of PEPRA, LACERA created two new retirement plans: General Plan G and Safety Plan C.

In addition to the establishment of new retirement plans, each public retirement system had to modify its plan under the County Employees Retirement Law of 1937 (CERL) to comply with the other requirements specified in PEPRA and avoid any unintentional conflicts.

For example, Government Code Section 31494.1 was amended in 2013 to make a technical change to remove an unintentional conflict with PEPRA. This provision enabled a member to elect an Open Window Plan Transfer from noncontributory Plan E to contributory Plan D. However, the provision defined the contributory plan as being the contributory plan otherwise available to new members of the retirement system. This would have placed the transferred member into Plan G instead of Plan D, which was not the intent. Amending Section 31494.1 removed the unintended conflict by

specifically defining Plan D as the contributory plan into which Plan E members were transferred.

ISSUE

A similar issue regarding the definition of the contributory plan has been identified with respect to LACERA's Prospective Plan Transfers that also requires a technical change in CERL to avoid the same type of unintended conflict with PEPRA.

Government Code Sections 31494.2 and 31494.5 enable Plan D members to prospectively transfer to Plan E and vice versa. However, Plan D is defined under Sections 31494.2 and 31494.5 as "the contributory retirement plan otherwise available to new members of the system on the transfer date." Although this definition correctly described Plan D prior to the January 1, 2013 effective date of PEPRA, the definition now conflicts with Plan G's status as the contributory retirement plan that is available to new members for those members whose Prospective Plan Transfer is effective on or after January 1, 2013.

PROPOSED SOLUTION

Staff proposes the following definition of Plan D for Sections 31494.2 and 31494.5 to remove the conflict with Plan G and bring the Prospective Plan Transfer provisions into conformity with PEPRA:

> "Retirement Plan D means the contributory retirement plan otherwise available to members between June 1, 1979 and December 31, 2012."

The proposed solution pertains to the CERL provisions that affect only LACERA and none of the other 1937 Act systems. Therefore, a proposal to the SACRS Legislative Committee is not the appropriate venue to achieve this objective. If approved by your Board, LACERA staff will work with LACERA's legislative advocate to seek an author for the proposed legislative change.

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IT IS THEREFORE RECOMMENDED THAT YOUR BOARD direct staff to work with LACERA's legislative advocate and seek an author to introduce legislation to amend the definition of Plan D in the Prospective Plan Transfer provisions of the County Employees Retirement Law of 1937.

Attachments

2015. Leg.LACERA 2016 Legislation.BOR.102215

GOVERNMENT CODE - GOV

TITLE 3. GOVERNMENT OF COUNTIES [23000 - 33205] *(Title 3 added by Stats. 1947, Ch. 424.)*

DIVISION 4. EMPLOYEES [31000 - 33017] *(Division 4 added by Stats. 1947, Ch. 424.)*

PART 3. RETIREMENT SYSTEMS [31200 - 33017] *(Part 3 added by Stats. 1947, Ch. 424.)*

CHAPTER 3. County Employees Retirement Law of 1937 [31450 - 31898] *(Chapter 3 added by Stats. 1947, Ch. 424.)*

ARTICLE 1.5. Alternative Plan for Counties with Populations in Excess of Six Million [31487 - 31495.6] *(Article 1.5 added by Stats. 1981, Ch. 910, Sec. 1.)*

31494.2. (a) A general member whose benefits are governed by Retirement Plan D may, during a period of active employment, elect to change plan membership and become a member, prospectively, in Retirement Plan E. The election shall be made upon written application signed by the member and filed with the board, pursuant to enrollment procedures and during an enrollment period established by the board, which enrollment period shall not occur more frequently than once every three years for that member. The change in plan membership shall be effective as of the transfer date, as defined in subdivision (d). Except as otherwise provided in this section, the rights and obligations of a member who elects to change membership under this section shall be governed by the terms of this article on and after the transfer date. Prior to the transfer date, the rights to retirement, survivors', or other benefits payable to a member and his or her survivors or beneficiaries shall continue to be governed by Retirement Plan D.

(b) Except as otherwise provided in this section, effective as of the transfer date, a member who has transferred to Retirement Plan E pursuant to this section and his or her survivors or beneficiaries shall receive retirement, survivors', and other benefits that shall consist of: (1) the benefits to which they are entitled under the terms of Retirement Plan E, but based on the member's service credited only under that plan, and payable at the time and in the manner provided under Retirement Plan E, and (2) the benefits to which they would have been entitled under the terms of Retirement Plan D had the member remained a member of Retirement Plan D, but based on the member's service credited only under that plan, and payable at the time and in the manner provided under Retirement Plan D. Except as otherwise provided in this section, the calculation of the member's, survivors', or beneficiaries' benefits under each plan shall be subject to that plan's respective, separate terms, including, but not limited to, the definitions of "final compensation" and provisions establishing cost-of-living adjustments, establishing minimum retirement age and service requirements, and governing integration with federal social security payments. Notwithstanding the foregoing, the aggregate service credited under both retirement plans shall be taken into account for the purpose of determining eligibility for and vesting of benefits under each plan.

(c) Notwithstanding any other provision of Retirement Plan D or Retirement Plan E:

(1) A member who has transferred to Retirement Plan E pursuant to this section may not retire for disability and receive disability retirement benefits under Retirement Plan D.

(2) If a member who has transferred to Retirement Plan E pursuant to this section dies prior to retirement, that member's survivor or beneficiary may not receive survivor or death benefits under Retirement Plan D but shall receive a refund of the member's contributions to Retirement Plan D together with all interest credited thereto.

(d) As used in this section:

(1) "Period of active employment" means a period during which the member is actively performing the duties of a full-time or part-time employee position or is on any authorized paid leave of absence, except a leave of absence during which the member is totally disabled and is receiving, or is eligible to receive, disability benefits, either during or after any elimination or qualifying period, under a disability plan provided by the employer.

(2) "Retirement Plan D" means the contributory retirement plan otherwise available to new members of the

system on the transfer date.

(3) "Retirement Plan E" means the noncontributory retirement plan established under this article.

(4) "Transfer date" means the first day of the first month that is at least 30 days after the date that the application is filed with the board to change plan membership under subdivision (a).

(e) This section shall only be applicable to Los Angeles County and shall not become operative until the board of supervisors of that county elects, by resolution adopted by a majority vote, to make this section operative in the county.

(Added by Stats. 2001, Ch. 778, Sec. 6. Effective October 13, 2001. Section conditionally operative by its own provisions.)

GOVERNMENT CODE - GOV

TITLE 3. GOVERNMENT OF COUNTIES [23000 - 33205] *(Title 3 added by Stats. 1947, Ch. 424.)*

DIVISION 4. EMPLOYEES [31000 - 33017] *(Division 4 added by Stats. 1947, Ch. 424.)*

PART 3. RETIREMENT SYSTEMS [31200 - 33017] *(Part 3 added by Stats. 1947, Ch. 424.)*

CHAPTER 3. County Employees Retirement Law of 1937 [31450 - 31898] *(Chapter 3 added by Stats. 1947, Ch. 424.)*

ARTICLE 1.5. Alternative Plan for Counties with Populations in Excess of Six Million [31487 - 31495.6] *(Article 1.5 added by Stats. 1981, Ch. 910, Sec. 1.)*

31494.5. (a) A general member whose benefits are governed by Retirement Plan E may, during a period of active employment, elect to change plan membership and become a member, prospectively, in Retirement Plan D. The election shall be made upon written application signed by the member and filed with the board, pursuant to enrollment procedures and during an enrollment period established by the board, which enrollment period shall not occur more frequently than once every three years for that member. The change in plan membership shall be effective as of the transfer date, as defined in subdivision (g). Except as otherwise provided in this section, the rights and obligations of a member who elects to change membership under this section shall be governed by the terms of Retirement Plan D on and after the transfer date. Prior to the transfer date, the rights to retirement, survivors', or other benefits payable to a member and his or her survivors or beneficiaries shall continue to be governed by Retirement Plan E.

(b) If a member has made the election to change plans under subdivision (a), monthly contributions by the member and the employer under the terms of Retirement Plan D shall commence as of the transfer date. For the purposes of calculating the member's contribution rate under Retirement Plan D, his or her entry age shall be deemed to be his or her age at his or her birthday nearest the transfer date; however, if the member exchanges service credit in accordance with subdivision (c), with regard to contributions made for periods after that exchange, his or her entry age shall be adjusted and deemed to be the member's age at his or her birthday nearest the date on which begins the most recent period of unbroken service credited under Retirement Plan D, taking into account service purchased under subdivision (c). In no event shall the exchange of service under subdivision (c) affect the entry age with respect to, or the cost of, employee contributions made, or service purchased, prior to the exchange.

(c) A general member who has elected to change plans under subdivision (a) also may elect to exchange, at that time or any time thereafter, but prior to the earlier of his or her application for retirement, termination from employment, or death, some portion designated in whole-month increments, or all of the service credited under Retirement Plan E for an equivalent amount of service credited under Retirement Plan D, provided, however, that the member may not exchange less than 12 months' service or, if less, the total service credited under Retirement Plan E. The exchange shall be effective on the date when the member completes the purchase of that service by depositing in the retirement fund, by lump sum or regular monthly installments, over the period of time determined by a resolution adopted by a majority vote of the board of retirement, or both, but in any event prior to the earlier of his or her death or the date that is 120 days after the effective date of his or her retirement, the sum of: (1) the contributions the member would have made to the retirement fund under Retirement Plan D for that length of time for which the member shall receive credit as service under Retirement Plan D, computed in accordance with the rate of contribution applicable to the member under Retirement Plan D, based upon his or her entry age, and in the same manner prescribed under Retirement Plan D as if that plan had been in effect during the period for which the member shall receive service credit, and (2) the regular interest thereon.

For the purposes of this subdivision, a member's entry age shall be deemed to be the member's age at his or her birthday nearest the date on which begins the most recent period of unbroken service credited under Retirement

Plan D following completion of the service exchange under this subdivision. A member may receive credit for a period of service under only one plan and in no event shall a member receive credit for the same period of service under both Retirement Plan D and Retirement Plan E.

A member who fails to complete the purchase of service as required under this subdivision shall be treated as completing an exchange of service under Retirement Plan E for an equivalent amount of service under Retirement Plan D only with regard to the service that actually has been purchased through completed deposit with the retirement fund of the requisite purchase amount, calculated in accordance with this subdivision.

(d) Except as otherwise provided in this section, effective as of the transfer date, a member who has transferred to Retirement Plan D pursuant to this section and his or her survivors or beneficiaries shall receive retirement, disability, survivors', death, or other benefits that shall consist of: (1) the benefits to which they are entitled under the terms of Retirement Plan D, but based on the member's service credited only under that plan, and payable at the time and in the manner provided under Retirement Plan D, and (2) the benefits to which they would have been entitled under the terms of Retirement Plan E had the member remained a member of Retirement Plan E, but based on the member's service credited only under that plan, and payable at the time and in the manner provided under Retirement Plan E. Except as otherwise provided in this section, the calculation of the portion of a member's or beneficiary's benefit that is attributable to each plan is subject to that plan's respective, separate terms, including, but not limited to, the definitions of "final compensation" and provisions establishing cost-of-living adjustments, establishing minimum age and service requirements, and governing integration with federal social security payments. Notwithstanding the foregoing, the aggregate service credited under both Retirement Plan D and Retirement Plan E shall be taken into account for the purpose of determining eligibility for, and vesting of, benefits under each plan.

(e) Notwithstanding any other provision of Retirement Plan D or Retirement Plan E, a member who transfers into Retirement Plan D under this section may retire for service-connected or nonservice-connected disability and receive disability benefits under Retirement Plan D only if he or she has either (1) completed two continuous years of active service after his or her most recent transfer date, or (2) earned five years of retirement service credit under Retirement Plan D after his or her most recent transfer date. Notwithstanding any other provision to the contrary, a member who becomes disabled and does not meet either of these conditions (1) may apply for and receive only a deferred or service retirement allowance, or (2) may elect to transfer prospectively back to Retirement Plan E, and for the purposes of calculating his or her retirement benefits under this section, shall in lieu of credit under Retirement Plan D be credited with service under Retirement Plan E as provided under subdivision (g) of Section 31488 during any period he or she is totally disabled and is receiving, or eligible to receive, disability benefits, either during or after any elimination or qualifying period, under a disability plan provided by the employer up to the earlier of the date he or she retires or no longer qualifies for disability benefits. If a member dies before he or she is eligible to retire and before completing either two continuous years of active service after the transfer date into Retirement Plan D or after earning five years of retirement service credit under Retirement Plan D after that transfer date, that member's beneficiary shall not be entitled to the survivor allowance under Section 31781.1 or 31781.12, if operative.

(f) Notwithstanding any other provisions of Retirement Plan D or Retirement Plan E, a member who has transferred to Retirement Plan D pursuant to this section and who retires for disability when eligible under this section and Retirement Plan D, may not also retire for service and receive service retirement benefits under Retirement Plan E. However, for the purpose of calculating disability benefits under Retirement Plan D, the "sum to which he or she would be entitled as service retirement" or his or her "service retirement allowance," as those terms are used in Sections 31726, 31726.5, and 31727.4, shall consist of the blended benefit to which the member would be entitled under subdivision (d) if he or she retired for service, not just the service retirement benefit to which he or she would be entitled under Retirement Plan D.

(g) As used in this section:

(1) "Active service" means time spent on active, on-the-job performance of the duties of a full-time or part-time position and on any authorized paid leaves of absence; provided, however, that any authorized paid leave of absence or part-time service shall not constitute active service if the leave of absence or part-time service is necessitated by a preexisting disability, injury, or disease. The board of retirement shall determine whether or not a leave of absence or part-time service is necessitated by a preexisting disability, injury, or disease, and thus excluded from the member's active service, based upon evidence presented by the employer and the member upon request by the board.

(2) "Entry age" means the age used for calculating the normal rate of contribution to Retirement Plan D with respect to a member who has transferred membership to Retirement Plan D under this section.

(3) "Period of active employment" means a period during which the member is actively performing the duties of a

full-time or part-time employee position or is on any authorized paid leave of absence, except a leave of absence during which the member is totally disabled and is receiving, or is eligible to receive, disability benefits, either during or after any elimination or qualifying period, under a disability plan provided by the employer.

(4) "Retirement Plan D" means the contributory retirement plan otherwise available to new members of the retirement system on the transfer date.

(5) "Retirement Plan E" means the noncontributory retirement plan established under this article.

(6) "Transfer date" means the first day of the first month that is at least 30 days after the date that the application is filed with the board to change plan membership under subdivision (a).

(h) This section shall only be applicable to Los Angeles County and shall not become operative until the board of supervisors of that county elects, by resolution adopted by a majority vote, to make this section operative in the county.

(Amended by Stats. 2010, Ch. 86, Sec. 3. Effective January 1, 2011. Section conditionally operative by its own provisions.)

LACERA

October 23, 2015

TO: Each Board Member
Board of Retirement
Board of Investments

FROM: Gregg Rademacher
Chief Executive Officer

FOR: November 4, 2015 Board of Retirement Meeting
November 10, 2015 Board of Investments Meeting

SUBJECT: **FOURTH QUARTILE SALARY RANGE AUTHORIZATION - CHIEF INVESTMENT OFFICER RECRUITMENT**

RECOMMENDATION

Delegate authority to the Chief Executive Officer to set the Chief Investment Officer's initial salary in the fourth quartile of the salary range.

CHIEF INVESTMENT OFFICER RECRUITMENT

LACERA is seeking to fill its vacant Chief Investment Officer position. Because of the Chief Investment Officer's (CIO) management level position and the position being critical to supporting the Board of Investments in fulfilling its fiduciary responsibilities, LACERA employed the services of the executive recruitment firm Egon Zehnder.

Egon Zehner's executive search team of Dominique Hansen and Arnaud Tesson began the CIO active recruitment September 2015. It is their task to actively seek out and recruit highly qualified executive level professionals working in comparable level positions.

ANTICIPATED SALARY REQUIREMENTS

Although LACERA's CIO position is considered highly coveted in the field of public retirement, LACERA must still offer a competitive salary and benefit package great enough to attract qualified candidates. Based on discussions with Egon Zehner, it is anticipated a salary level in the fourth quartile of the Chief Investment Officer's salary range may be needed to attract qualified candidates suited for the responsibilities of this position.

In accordance with LACERA's provisions of Los Angeles County Code, Section 6.127.040(M)(1),

> "The retirement administrator may designate a salary at any rate within the first three quartiles of the Salary range established for the position to which the person is being appointed. Appointment at a salary rate within the fourth quartile of the Salary range shall require prior approval by the Board of Retirement and Board of Investments jointly."

To attract, recruit, hire, and retain a qualified Chief Investment Officer candidate, and to reduce future delays in the hiring process, it is requested the LACERA boards authorize the Chief Executive Officer's use of the fourth quartile of the Chief Investment Officer's assigned salary range, as needed, for negotiating salary of the selected candidate.

CHIEF INVESTMENT OFFICER'S SALARY RANGE

LACERA's Chief Investment Officer is currently assigned to Range 25 of LACERA's Tier I, Management Appraisal and Performance Plan (MAPP) salary schedule. The salary range currently in effect for this position is $270,350 to $409,190, with a top quartile (fourth quartile) salary range of $374,480 to $409,190.

IT IS THERFORE RECOMMENDED THAT YOUR BOARD delegate authority to the Chief Executive Officer to set the Chief Investment Officer's initial salary in the fourth quartile of the salary range.

GR:nm
CIO 4th Quartile Salary Utilization 2015gr.doc

C: John Nogales

LACERA

October 23, 2015

TO: Each Member
Board of Retirement
Board of Investments

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: November 4, 2015 Board of Retirement Meeting
November 10, 2015 Board of Investments Meeting

SUBJECT: **STAFF REPORT – 2015 Enacted Retirement Legislation**

Several bills amending the County Employees Retirement Law of 1937 (CERL) and the California Public Employees' Pension Reform Act of 2013 (PEPRA) were enacted in the first year of the 2015-2016 Legislative Session. Unless otherwise noted, the sections added or amended by these bills become effective January 1, 2016.

Section I lists a bill amending the LACERA retirement plans without further action by the Board of Supervisors or the Board of Retirement. Section II lists bills that amend CERL or PEPRA but do not require implementation because the subject matter of the bills does not apply to LACERA.

I. BILLS AMENDING THE LACERA PLANS WITHOUT FURTHER ACTION BY THE BOARD OF SUPERVISORS OR LACERA BOARDS

AB 992 (Chapter 40): Disability Retirement

Summary: Under Government Code Section 31725.7, members who filed an application for disability retirement may retire for service, if eligible, while the application is pending. If the member is later granted disability retirement, appropriate adjustments are made to the retirement allowance retroactive to the effective date of disability retirement. If the member initially retired for service and a disability retirement is later granted, the optional or unmodified type of allowance selected by the member when he or she retired for service is not binding.

Government Code Section 31760, however, precludes changes to a member's retirement election after receipt of the first payment of a retirement allowance. LACERA proposed this bill to the State Association of County Retirement Systems' Legislative Committee for sponsorship in its 2015 legislative platform to remove the conflict between Sections 31725.7 and 31760. The bill adds a subdivision to Section 31760 to clarify that a member who retired for service pursuant to Section 31725.7 and is later

granted a disability retirement may change his or her optional or unmodified type of allowance that was selected when his or her service retirement was granted.

Board of Retirement Position: Support

Implementation Issues: No change to LACERA administrative operations are required by AB 992 since this bill merely provided clarification for our current practices.

II. BILLS AMENDING CERL OR PEPRA THAT DO NOT APPLY TO LACERA

AB 284 (Chapter 66): San Juan Capistrano (Orange County)

Summary: The city of San Juan Capistrano is a participating agency in the Orange County Employees Retirement System (OCERS). In 2014, the city negotiated a memorandum of understanding with its labor unions to provide new nonsafety employees hired on or after January 1, 2015 the option of electing an alternative plan to the plan required by the PEPRA. The alternative plan (Plan W) is a hybrid plan that contains defined benefit and defined contribution components.

PEPRA requires that employers who adopt a new defined benefit formula after January 1, 2013 must have the California Legislature make findings and approve the plan. The bill does not actually amend CERL or PEPRA; it finds and declares that the defined benefit component of the plan has been certified and determined by the OCERS board and actuary as representing no greater risk and no greater cost to the employer than the defined benefit formula provided by PEPRA and that the Legislature approves the defined benefit formula.

Board of Retirement Position: Watch

Implementation Issues: N/A

AB 663 (Chapter 38): Alternate Member (Ventura County)

Summary: This bill authorizes the board of supervisors of Ventura County to appoint an alternate member for the fourth, fifth, sixth, or ninth member of the retirement board of the Ventura County Employees' Retirement Association, i.e., the Board of Supervisors' appointees. The term of office of the alternate member runs concurrently with the term of office of the ninth member.

The alternate member shall vote as a member of the board only in the event that the fourth, fifth, sixth, or ninth member is absent from a board meeting. If there is a vacancy

with respect to the fourth, fifth, sixth, or ninth member, the alternate member shall fill the vacancy until a successor qualifies. The alternate member is entitled to the same compensation as the other appointed members of the board.

Board of Retirement Position: Watch

Implementation Issues: N/A

AB 868 (Chapter 86): PERS Transfer (San Bernardino County)

Summary: Contracting agencies with the Public Employees' Retirement System (PERS) may terminate the participation of their safety members in the PERS retirement plan and transfer the members into a county retirement system pursuant to an agreement between the PERS board of administration and the board of retirement of a county retirement system.

The counties of Kern, Los Angeles, and Orange can enter into transfer agreements with the PERS board of administration. This bill expands the application of the provisions to San Bernardino County.

Board of Retirement Position: Watch

Implementation Issues: N/A

AB 1291 (Chapter 223): District (Ventura County)

Summary: The retirement systems of Orange County, San Bernardino County, and Contra Costa County are included within the definition of "district" in CERL.

This bill provides for the Ventura County Employees' Retirement Association (VCERA) to be included within the definition of "district" in CERL. The VCERA board of retirement may appoint specified management personnel as employees of the retirement system rather than the county; all other personnel remain employees of the county. The appointed personnel are not subject to the civil service system, and their terms of employment are determined by the VCERA board of retirement.

Board of Retirement Position: Watch

Implementation Issues: N/A

SB 354 (Chapter 158): Joint Powers Authority (Cities of Brea and Fullerton)

Summary: The cities of Brea and Fullerton contract with the Public Employees' Retirement System (PERS) for retirement benefits. The Joint Exercise of Powers Act authorizes the two cities to form a joint powers authority (JPA) to exercise a common power such as hiring employees and establishing a retirement system.

The California Public Employees' Pension Reform Act of 2013 (PEPRA) authorizes the Brea and Fullerton JPA formed on or after January 1, 2013 to provide employees who are not new members ("legacy members") the defined benefit plan that was in effect on December 31, 2012. The JPA will contract with PERS to provide retirement benefits for its employees.

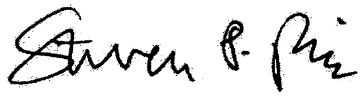
This bill clarifies the period during which legacy members employed by the cities of Brea and Fullerton can transfer to the JPA and retain the defined benefit plan they were participating in prior to the transfer. Legacy members will be provided the defined benefit plan they were participating in prior to the formation of the JPA if they are subsequently employed by the JPA within 180 days of the formation of the JPA.

Board of Retirement Position: Watch

Implementation Issues: N/A

Copies of these chaptered bills are available upon request.

Reviewed and Approved:



Steven P. Rice, Chief Counsel

LACERA

FOR INFORMATION ONLY

DATE: October 27, 2015

TO: Each Member,
Board of Retirement
Each Member,
Board of Investments

FROM: Steven P. Rice SPR
Chief Counsel

FOR: November 4, 2015 Board of Retirement Meeting
November 10, 2015 Board of Investments Meeting

SUBJECT: **UPDATE ON NEW PROPOSED REED DeMAIO INITIATIVES**

Attached is a memo from fiduciary counsel Chris Waddell, of Olson Hagel & Fishburn, concerning the two new Reed DeMaio public pension initiative proposals. Also attached are copies of the proposed initiatives themselves. We may bring Mr. Waddell back to speak to the Boards following issuance of the Titles and Summaries by the Attorney General (which should be by December 9, 2015) or based on other future developments.

Reviewed and Approved:

for Gregg Rademacher
Chief Executive Officer

Attachments

c: Gregg Rademacher
Robert Hill
John J. Popowich

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MEMORANDUM

DATE: October 27, 2015

TO: Each Board Member, Board of Retirement and Board of Investments

CC: Gregg Rademacher, Chief Executive Officer
Steven P. Rice, Chief Counsel

FROM: Christopher W. Waddell, Senior Attorney

RE: Summary and Analysis of New Reed/DeMaio Initiatives—the Voter Empowerment Act and the Government Pension Cap Act

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This memorandum analyzes the two new initiative ballot measures that were submitted by Chuck Reed and Carl DeMaio together with other proponents to the Attorney General for Title and Summary on October 5, 2015. The first is a new version of the "Voter Empowerment Act of 2016" that was previously submitted by the proponents and was the subject of presentations by our firm to the Boards of Retirement and Investment on August 13 and September 9, respectively. We will refer to this measure as the "new VEA." The second is an entirely new measure called the "Government Pension Cap Act of 2016." We will refer to this measure as the "PCA." Both measures were amended by the proponents on October 20, 2015 and our discussion reflects the language of the measures as amended.

By way of brief overview, the primary difference between the new VEA and the prior version is that the new VEA does not include the broad language that would have allowed voters, notwithstanding contrary constitutional and statutory provisions, to pass initiative measures that would affect the retirement benefits and compensation of current government employees. The new VEA retains the other features of the original, including 1) requiring voter approval for enhancements of defined benefit plans for both current and new employees 2) closing all defined benefit plans to new employees as of January 1, 2019 absent approval by the voters of the applicable jurisdiction; and 3) prohibiting government employers from paying more than one-half of the costs of retirement

benefits for new government employees absent approval by the voters of the applicable jurisdiction. There are a number of language differences between these provisions in the prior and new versions and while most appear to be non-substantive we will identify those with any possible significance.

The PCA, on the other hand, takes an entirely different approach. Instead of closing existing defined benefit plans to new employees, it would establish strict limits on government employer retirement benefit contributions for new employees as of January 1, 2019, defining such benefit contributions broadly to include not only defined benefit (both normal cost and any unfunded liabilities) and defined contribution plans but retiree healthcare, Medicare, Social Security, and other forms of deferred compensation. The PCA also includes the VEA provision prohibiting government employers from paying more than one-half of the costs of retirement benefits for new government employees.

We will first provide a brief comparison of the new VEA with the prior VEA and describe the likely impacts of the new VEA. We will then provide a summary of the PCA and a preliminary evaluation of the potential impacts of that measure. We will close with a summary of the applicable deadlines with respect to the potential qualification of either of these measures for the ballot.

I. Comparison of New VEA With Previous VEA

Like the previous VEA, the new VEA also adds a new section 23 to Article XVI of the Constitution. The most significant changes between the old proposal and the new proposal are that the new proposal 1) eliminates the broad "notwithstanding" clause which would have overridden other constitutional provisions as well as statutes; 2) eliminates the broad authority given to voters to determine the "amount and manner in which compensation and retirement benefits are provided;" and 3) eliminates former (j), stated that nothing in the measure should be interpreted to reduce benefits "for work performed." There is also a new express declaration in (f) that the measure "shall not be interpreted to amend or modify section 9 of Article 1 [the Contracts Clause] (Section 23(f)). The new VEA otherwise retains the following key features of the original:

(a) Prohibits "benefit enhancements" to employees in a DB plan without voter approval. What is now section 23(a) of the measure would provide that:

Government employers shall not provide a benefit enhancement to any government employee in a defined benefit pension plan unless the voters of that jurisdiction approve that enhancement.

This language is similar to that in the original measure, except that the original stated that employers "shall not enhance the pension benefits of any employee" while the new language

provides that employers "shall not provide a benefit enhancement to any government employee." It's unclear whether a distinction was intended and whether "providing" a benefit enhancement is broader than enhancing benefits. The language defining "benefit enhancement" is largely the same in both, with the significant exception that the new language includes "reducing the employee's share of costs" in the definition of an enhancement (Section 23(h) (5).

(b) Prohibits placing new employees in DB plans absent voter approval. What is now section 23(b) of the measure would provide that:

Government employers may only enroll new government employees in a defined benefit pension plan if the voters of that jurisdiction approve enrollment in such a plan.

While this language is slightly different from prior language, the change does not appear to be substantive. However, the October 20, 2015 amendment significantly changes the definition of "new employee" so as to exclude employees eligible for reciprocity and those who, after a break in service of six months or less, change employers within the same system (Section 23 (h) (1) (B) and (C)). As a result, current employees that meet either of these criteria would be able to remain in a defined benefit plan after the effective date of the measure.

(c) Prohibits employers from paying more than half of "total cost of retirement benefits" for new employees without voter approval. What is now section 23(c) would provide that:

Government employers shall not pay more than one-half of the total cost of retirement benefits for new government employees unless the voters of that jurisdiction have approved paying that higher proportion.

We note that language in the prior VEA provision specifically included "unfunded liability costs." Although this reference has been deleted, the term "total cost" is ambiguous and may nevertheless include unfunded liability costs even with this deletion.

The new VEA also carries forward these other provisions from the prior version, with some language changes.

(d) Prohibits retirement boards from imposing fees, accelerating payments or imposing other financial conditions on closing a DB plan to new members unless voters approve the conditions. This is the same language as prior measure.

(e) Eliminates non-judicial forums for challenges to government employer or retirement system compliance with measure. As we discussed previously, the primary effect of this language is to eliminate jurisdiction of the Public Employment Relations Board (PERB) over disputes arising from the compliance by government employers or retirement boards with the measure. The language is similar to prior language but, consistent with the deletion of former

subsection (a) and the "Notwithstanding" clause, language referencing challenges to initiatives and referenda have been deleted.

(f) No effect on existing labor agreements; no effect on Contracts Clause. The new VEA contains the same language as the prior measure with respect to the measure not affecting existing labor agreements but applies to new agreements entered into after the effective date of the measure. The new measure adds this language: "Nothing in this section shall be interpreted to amend or modify section 9 of Article 1," which is a reference to the Contracts Clause of the California Constitution.

(g) Death and disability benefits. The new VEA has the same language as prior version saying that it is not intended to modify or limit death and disability benefits or require voter approval for those benefits.

II. Impact of New VEA

In our analysis of the previous VEA, we concluded that 1) it was intended to eliminate the California Rule, i.e., the constitutional protection for retirement benefits; 2) it would allow local initiatives and referenda to potentially eliminate most state control over retirement benefits and potentially threaten the fiscal stability of existing retirement plans; 3) the use of initiative and referenda would undermine (and potentially eliminate) collective bargaining and de-stabilize employment relations; and 4) the elimination of most defined benefit plans would make it logistically impossible or extremely expensive to obtain comparable death and disability benefits. We believe that, although the new VEA proposal would have somewhat different impacts and effects, there are elements of each of the above impacts that are still present.

A. Vested Rights of Current Employees

As we discussed in our prior presentations to the Boards, employee retirement benefits are subject to the "vested rights" doctrine, which has two components in California. First, an employee is considered to be exchanging his/her labor for the promised benefit; therefore, once work has been performed, the benefit has been earned and cannot legally be altered or modified. In California, the vested right has been held to include the right to benefits for future work on roughly the same terms as those in effect when employment commenced. (*Legislature v. Eu* (1991) 54 Cal.3d 492) This protection for future accruals is called the "California rule" and has been held to be protected against impairment by the State and Federal Contracts Clauses. Second, employees in a defined benefit plan are entitled to an actuarially sound system, i.e., a system that is funded at a level sufficient to provide the promised benefits. (*Bd. of Admin. v. Wilson* (1997) 52 Cal.App.4th 1109.)

The new VEA purports to go to some lengths *not* to interfere with vested rights. As noted above, it has eliminated the notwithstanding provision coupled with broad initiative power

over compensation; it has eliminated the reference to protecting benefits for "work performed," and it affirmatively states that it does not intend to amend or modify the Contracts Clause. However, vested rights issues still exist with the current measure.[1] One such concern is with the measure's potential impact on the vested right to an actuarially sound system. As we previously discussed, the restriction on governing boards imposing termination fees, accelerate payments on existing debt, or other financial conditions on governmental employers proposing to close defined benefit plans, which is carried forward verbatim from the prior version of the VEA, is ambiguous. It is unclear whether it applies in the case of a plan closure versus a plan termination, or whether it applies to plan closures occurring by operation of the measure (i.e., after January 1, 2019) as opposed to closures proposed separately by a government employer. Significantly, the phrase "other financial conditions" is sufficiently ambiguous as to call into question whether it would prevent retirement boards from taking appropriate action to adopt more conservative asset allocations that result in lower assumed investment rates as closed plans mature when one result of such action would be increased employer contributions. If interpreted to prevent such action to maintain the actuarial soundness of benefits already earned by current employees, this aspect of the measure would likely be found to impair those employees' vested rights. As a separate matter, the imposition of a requirement of voter approval for any benefit enhancement provided to current employees where such a requirement did not previously exist is a potential vested rights concern.

B. Impact on Death and Disability Benefits for New Employees

The new proposal (like the prior version) provides that the measure does not limit disability and/or death benefits and that voter approval is not required for such benefits. However, for reasons we previously discussed with you, it is unlikely that existing levels of disability and death benefits can be provided in the absence of a defined benefit plan. Even if it were possible to replicate existing disability benefit levels, the costs of providing such benefits

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[1] Prior to the October 20, 2015 amendment, the new VEA contained an obvious impairment of the vested retirement rights of current members. Like the original, it continued to define "new government employee" includes any employee hired after January 1, 2019, irrespective of any prior employment status (with the limited exception of a return from disability leave). The combination of the closing of all defined benefit plans to "new employees" after January 1, 2019 and the broad scope of the definition of "new employee" would have resulted in the elimination not only of existing reciprocity rights held by current employees but also the right of such current employees to retain their existing pension plan if changing employers within the same plan and the right to reinstate to plan membership after a leave of absence or most separations from service. This would have resulted in a significant impairment of such members' vested rights, and, as we discussed previously, would create a huge disincentive for current employees to change employers, with concomitant recruitment problems for governmental employers. By excluding current employees who are eligible for reciprocity or who, after a break in service of six months or less, change employers within the same system, the amendments largely eliminate this concern. However, there may be a subset of current employees who would otherwise be eligible under existing law to reinstate to membership in a defined benefit plan with a different employer after a break of service of more than six months whose vested rights would be impaired. We are continuing to analyze this issue.

outside a DB plan would be significantly higher than the current costs. And, in the absence of an underlying DB plan, the cost cannot be distributed between employers and employees in a way that makes the death and disability plan economically feasible.

C. Other Impacts on New Employees

Plainly, the most significant impact on new employees is that, in the absence of voter approval they will be unable to enroll in a DB plan. There is no requirement that government employers enroll new employees in a defined contribution plan. If they are not, government employers will either have to enroll such employees in Social Security (if the employer is not already participating in that system) or provide an alternative plan to Social Security that meets federal requirements. Even in the event that voters allow new employees to enroll in defined benefit plans, we noted several concerns with the 50/50 cost sharing requirement in the prior measure and these concerns continue to exist with the new version. As we previously observed, there is nothing in the measure that would prevent voters from keeping existing DB plans open but not approving exceptions to the 50% cap on employer costs. And, while the explicit reference to unfunded liability costs has been deleted from the definition of benefit costs, the continuing reference to "total costs" leaves open the possibility that the cap would apply to unfunded liability costs as well. As a result, as with the prior version there is a risk of unaffordable employee contributions resulting from the measure, particularly given that given that the 50% employer cap includes retiree healthcare costs.

D. Impact on Collective Bargaining

California allows public employees the right to collectively bargain over conditions of employment and compensation, including benefits such as retirement, health and disability. The new VEA would make broad areas within the scope of collective bargaining subject to voter approval, i.e., enrollment of new employees in a DB plan, the amount of the government employer's contributions (if more than 50%) of contributions, and any "benefit enhancement" (now defined to include any reduction in employee costs). The latter, in particular, means that any increase in pension benefits must be approved by the voters even if part of a package that decreases overall employer costs, or includes one change in the defined benefit plan that provides a small increase in benefits with a negligible cost that is offset by a significant reduction in benefits that would result in significant overall cost savings. This makes it less likely that unions and employers will seek to negotiate such agreements because of the uncertainty of voter approval and the costs of running the election. This would likely also drive up other non-retirement compensation costs in order to attract and maintain a sufficiently qualified workforce.

III. The Government Pension Cap Act (PCA)

This initiative also adds a new section 23 to Article XVI of the Constitution, which would limit government employers' retirement benefit contribution to 11% of base compensation

for new employees and 13% for new safety employees. However, retirement benefits are defined. This initiative also adds a new section 23 to Article XVI of the Constitution, which would limit government employers' retirement benefit contribution to 11% of base compensation for new employees and 13% for new safety employees. However, retirement benefits are defined differently than under VEA and the cap would apply to any combination of contributions to DB (including contributions to amortize any unfunded liabilities) and/or DC plans, retiree healthcare, Social Security, and any other form of deferred compensation. The October 20, 2015 amendments expressly include employer contributions to Medicare within this definition. Employer contributions for death and disability benefits are excluded from the contributions cap.

The PCA defines "new safety employee" as a new employee "who is also a police officer or sheriff duly certified in their law enforcement position, any licensed firefighter, any prison guard, or other classification the government employer finds is a high risk law enforcement or public safety position." The PCA defines "base compensation" as:

... the regular annual base pay of the individual public employee and reflective of regular base pay of similarly situated employees of the same group or class of employment for services rendered on a full-tie basis during normal working hours, pursuant to publicly available pay schedules, and subject to any exclusions as defined in California Government Code Section 7422.34 as it existed on September 1, 2015. (Section 23 (g) (5)).

This definition is essentially identical to the PEPRA definition of pensionable compensation (Cal. Gov't Code §7522.34).

The PCA also has a section similar to the VEA that prohibits a government employer from paying more than 50% of the "total cost of retirement benefits" (as defined above) for new government employees without voter approval (Section 23(b)). It states that nothing in the Act limits the ability of the government employer to offer a DB plan, a DC plan, or a combination thereof, subject to the spending limitations (Section 23(e)).

The broad scope of the definition of retirement benefits under the PCA makes the caps highly problematic. For example, according to its latest actuarial valuation the PEPRA tier normal cost for LACERA is 15.08% for non-safety and 27.78% for safety. While the levels in the measure would cover 50% of the normal cost for non-safety members and almost (but not quite) cover it for safety members, this does not account for Social Security (if applicable), Medicare, any employer matches to deferred compensation plans, and any future unfunded liability costs that may arise in a defined benefit plan.[2]. As a result, while the PCA does not preclude a defined benefit plan for new employees after January 1, 2019, designing such a plan within the applicable employer contribution caps that includes other retirement costs would

[2] But for the fact that retiree health benefits are provided to County of Los Angeles employees on a non-contributory basis, the added effect of these costs with respect to the PCA caps would be a significant concern. For new employees in many other jurisdictions, this will exacerbate the effect of the PCA caps.

likely result in either huge employee costs or a much-reduced benefit structure even as compared to PEPRA.

The PCA also contains provisions identical to those in the VEA described in subsections (e) (PERB jurisdiction and (f) (existing collective bargaining agreements). Regarding death and disability benefits, the PCA states that:

Government employers may provide disability benefits and death benefits for new employees which are not subject to the limitations of this section (Section 23(f)).

Notwithstanding the absence of caps on employer contributions towards death and disability benefits, our very preliminary assessment is that, similar to the VEA, providing death and disability benefits comparable to those currently in existence will both extremely difficult and much more expensive than is currently the case.

IV. Process and Deadlines

The Legislative Analyst and Department of Finance must submit their joint estimate of any financial impacts resulting from the measures within 50 days after October 5, 2015, which is November 24, 2015. This date is not extended by the amendment of the measures. (Cal. Elec. Code §9005(c). The Attorney General has 15 days from that date to issue a circulating title and summary, which is December 9, 2015. (Cal. Elec. Code §9004). Thereafter, the proponents have 180 days within which to circulate either or both measures for signature. (Cal. Elec. Code §9014) However, the Secretary of State recommends a deadline of April 26, 2016 by which to submit petitions to provide sufficient time for signature verification in order to qualify for the November 8, 2016 ballot, which would leave the proponents with 139 days to gather signatures.

VOTER EMPOWERMENT ACT OF 2016

Voter Empowerment Act of 2016

SECTION 1. TITLE.

This measure shall be known and may be cited as "The Voter Empowerment Act of 2016."

SECTION 2. STATEMENT OF FINDINGS AND PURPOSE.

(a) Government has an obligation to provide essential services that protect the safety, health, welfare, and quality of life enjoyed by all Californians. State and local governments face elimination or reduction of essential services because of costly, unsustainable retirement benefits granted to new government employees.

(b) Almost all of these benefits were granted without the consent of voters. Consequently, the need to empower voters to approve retirement benefits for government employees is a matter of statewide concern.

(c) Therefore, the people hereby amend the Constitution to reform retirement benefits granted to new government employees and to require voters to approve or reject increases in defined benefits proposed for any government employees.

SECTION 3. Section 23 of Article XVI of the California State Constitution is added to read:

Sec. 23 (a) Government employers shall not provide a benefit enhancement to any new government employee in a defined benefit pension plan unless the voters of that jurisdiction approve that enhancement.

(b) Government employers may only enroll new government employees in a defined benefit pension plan if the voters of that jurisdiction approve enrollment in such a plan.

(c) Government employers shall not pay more than one-half of the total cost of retirement benefits for new government employees unless the voters of that jurisdiction have approved paying that higher proportion.

(d) ~~Retirement boards shall not impose termination fees, accelerate payments on~~ existing debt, or impose other financial conditions against a government employer that proposes to close a defined benefit pension plan to new members, unless voters of that jurisdiction or the sponsoring government employer approve the fees, accelerated payment, or financial conditions.

(e) Challenges to the actions of a government employer or a retirement board to comply with requirements of this section may only be brought in the courts of California exercising judicial power as provided in Article VI or in the courts of the United States.

(f) Nothing in this section shall alter any provisions of a labor agreement in effect as of the effective date of this Act, but this Section shall apply to any successor labor agreement, renewal or extension entered into after the effective date of this Act. Nothing in this section shall be interpreted to amend or modify section 9 of Article I.

(g) Nothing in this section shall be interpreted to modify or limit any disability benefits provided for government employees or death benefits for families of government employees, even if those benefits are provided as part of a retirement benefits system. Nothing in this section shall be interpreted to require voter approval for death or disability benefits.

(h) For the purpose of this section, the following definitions shall be applied:

(1) "New employee" means any of the following:

(A) An individual who becomes a member of any state or local public retirement system in California for the first time on or after January 1, 2019, and who was not a member of any other state or local public retirement system in California prior to that date.

(B) An individual who becomes a member of a state or local public retirement system in California for the first time on or after January 1, 2019, and who was a member of another public retirement system prior to that date, but who was not subject to reciprocity under subdivision (c) of California Government Code Section 7522.02 as it existed on September 1, 2015.

(C) An individual who was an active member in a state or local retirement system in California and who, after a break in service of more than six months, returned to active membership in that system with a new employer. For purposes of this subdivision, a change in employment between state entities or from one school employer to another shall not be considered as service with a new employer.

(2) "Government employer" means the state, or a political subdivision of the state including, but not limited to, counties, cities, charter counties, charter cities, charter city and counties, school districts, special districts, boards, commissions, the Regents of the University of California, California State University, and agencies thereof.

(3) A "defined benefit pension plan" means a plan that provides lifetime payments to retirees and survivors based upon a formula using factors such as age, length of service or final compensation.

(4) "Retirement benefits" includes defined benefit pension plans, defined contribution plans, retiree healthcare plans, or any form of deferred compensation offered by government employers.

(5) A "benefit enhancement" means any change in a defined benefit pension plan that increases the value of an employee's benefit including, but not limited to, reducing employee's share of cost, increasing a benefit formula, increasing the rate of cost of living adjustments, expanding the categories of pay included in pension calculations, reducing a vesting period, lowering the eligible retirement age, or otherwise providing an economic advantage for government employees in a defined benefit plan, except for the disability component of any defined benefit plan.

SECTION 4. GENERAL PROVISIONS.

(a) This Act is intended to be comprehensive. It is the intent of the People that in the event this Act and one or more measures relating to the same subject shall appear on the same statewide election ballot, the provisions of the other measure or measures shall be deemed to be in conflict with this Act. In the event that this Act receives a greater number of affirmative votes, the provisions of this Act shall prevail in their entirety, and all provisions of the other measure or measures shall be null and void.

(b) If any provision of this Act, or part thereof, or the applicability of any provision or part to any person or circumstances, is for any reason held to be invalid or unconstitutional, the remaining provisions and parts shall not be affected, but shall remain in full force and effect, and to this end the provisions and parts of this Act are severable. The voters hereby declare that this Act, and each portion and part, would have been adopted irrespective of whether any one or more provisions or parts are found to be invalid or unconstitutional.

(c) This Act is an exercise of the public power of the people of the State of California for the protection of the health, safety, and welfare of the people of the State of California, and shall be liberally construed to effectuate its purposes.

(d) Notwithstanding any other provision of law, if the State, government agency, or any of its officials fail to defend the constitutionality of this act, following its approval by the voters, any other government employer, the proponent, or in his or her absence, any citizen of this State shall have the authority to intervene in any court action challenging the constitutionality of this act for the purpose of defending its constitutionality, whether such action is in trial court, on appeal, and on discretionary review by the Supreme Court of California and/or the Supreme Court of the United States. The fees and costs of defending the action shall be a charge on funds appropriated to the Attorney General, which shall be satisfied promptly.

GOVERNMENT PENSION CAP ACT OF 2016

Government Pension Cap Act of 2016

SECTION 1. TITLE.

This measure shall be known and may be cited as "Government Pension Cap Act of 2016."

SECTION 2. STATEMENT OF FINDINGS AND PURPOSE.

(a) Government has an obligation to provide essential services that protect the safety, health, welfare, and quality of life enjoyed by all Californians. State and local governments face reduction or elimination of essential services because of costly, unsustainable retirement benefits granted to government employees.

(b) Almost all of these benefits were granted without the consent of voters. Consequently, the need to empower voters to reform retirement benefits for new government employees is a matter of statewide concern.

(c) Therefore, the people hereby amend the Constitution to limit the cost of retirement benefits granted to new government employees and to empower voters to approve or reject any proposed increases in those limits.

SECTION 3. Section 23 of Article XVI of the California State Constitution is added to read as follows:

Sec. 23 (a) Government employers shall not contribute more than 11 percent of base compensation for a new employee's retirement benefits. Government employers shall not contribute more than 13 percent of base compensation for a new safety employee's retirement benefits. All other costs, including unfunded liability costs, of a new employee's retirement benefits shall be the responsibility of the employee, unless the voters of that jurisdiction establish a new limitation.

(b) Government employers shall not pay more than one-half of the total cost of retirement benefits for new government employees unless the voters of that jurisdiction have approved paying that higher proportion.

(c) Challenges to the actions of a government employer or retirement board to comply with requirements of this section may only be brought in the courts of California exercising judicial power as provided in Article VI or in the courts of the United States.

(d) Nothing in this section shall alter any provisions of a labor agreement in effect as of the effective date of this Act, but this Section shall apply to any successor labor agreement, renewal or extension entered into after the effective date of this Act. Nothing in this section shall be interpreted to amend or modify section 9 of Article I.

(e) Nothing in this section shall be interpreted to limit the ability of government employers to offer defined benefit pension plans or defined contribution plans or a combination of both plans for new employees, subject to the limitations in this section.

(f) Government employers may provide disability benefits and death benefits for new employees which are not subject to the limitations of this section.

(g) For the purpose of this section, the following definitions shall be applied:

(1) "New employee" means any of the following:

(A) An individual who becomes a member of any state or local public retirement system in California for the first time on or after January 1, 2019, and who was not a member of any other state or local public retirement system in California prior to that date.

(B) An individual who becomes a member of a state or local public retirement system in California for the first time on or after January 1, 2019, and who was a member of another public retirement system prior to that date, but who was not subject to reciprocity under subdivision (c) of California Government Code Section 7522.02 as it existed on September 1, 2015.

(C) An individual who was an active member in a state or local retirement system in California and who, after a break in service of more than six months, returned to active membership in that system with a new employer. For purposes of this subdivision, a change in employment between state entities or from one school employer to another shall not be considered as service with a new employer.

(2) "Government employer" means the state, or a political subdivision of the state including, but not limited to, counties, cities, charter counties, charter cities, charter city and counties, school districts, special districts, boards, commissions, the Regents of the University of California, California State University, and agencies thereof.

(3) "Retirement benefits" includes defined benefit pension plans, defined contribution plans, retiree healthcare plans, Medicare, Social Security, or any form of deferred compensation provided by government employers. "Retirement benefits" does not include death and disability benefits.

(4) A "new safety employee" means any new government employee as defined in (g) (1) who is also a police officer or sheriff duly certified in their

law enforcement position, any licensed firefighter, any prison guard, or other classification the government employer finds is a high risk law enforcement or public safety position.

(5) "Base compensation" means the regular annual base pay of the individual public employee and reflective of regular base pay of similarly situated employees of the same group or class of employment for services rendered on a full-time basis during normal working hours, pursuant to publicly available pay schedules, and subject to any exclusions as defined in California Government Code Section 7422.34 as it existed on September 1, 2015.

SECTION 4. GENERAL PROVISIONS.

(a) This Act is intended to be comprehensive. It is the intent of the People that in the event this Act and one or more measures relating to the same subject shall appear on the same statewide election ballot, the provisions of the other measure or measures shall be deemed to be in conflict with this Act. In the event that this Act receives a greater number of affirmative votes, the provisions of this Act shall prevail in their entirety, and all provisions of the other measure or measures shall be null and void.

(b) If any provision of this Act, or part thereof, or the applicability of any provision or part to any person or circumstances, is for any reason held to be invalid or unconstitutional, the remaining provisions and parts shall not be affected, but shall remain in full force and effect, and to this end the provisions and parts of this Act are severable. The voters hereby declare that this Act, and each portion and part, would have been adopted irrespective of whether any one or more provisions or parts are found to be invalid or unconstitutional.

(c) This Act is an exercise of the public power of the people of the State of California for the protection of the health, safety, and welfare of the people of the State of California, and shall be liberally construed to effectuate its purposes.

(d) Notwithstanding any other provision of law, if the State, government agency, or any of its officials fail to defend the constitutionality of this act, following its approval by the voters, any other government employer, the proponent, or in his or her absence, any citizen of this State shall have the authority to intervene in any court action challenging the constitutionality of this act for the purpose of defending its constitutionality, whether such action is in trial court, on appeal, and on discretionary review by the Supreme Court of California and/or the Supreme Court of the United States. The fees and costs of defending the action shall be a charge on funds appropriated to the Attorney General, which shall be satisfied promptly.

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