AGENDA

THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 NORTH LAKE AVENUE, SUITE 810
PASADENA, CA 91101

9:00 A.M., THURSDAY, November 9, 2017 **

The Committee may take action on any item on the agenda, and agenda items may be taken out of order.

COMMITTEE MEMBERS:

Vivian H. Gray, Chair
Marvin Adams, Vice Chair
Alan Bernstein
Ronald Okum
David Muir, Alternate

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of September 6, 2017

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Release of Psychiatric/Psychological Medical Records to Unrepresented Applicants

B. Proposed Panel Physician Guidelines

C. Consider Application of Frank Guellich, M.D., as a LACERA Panel Physician

IV. FOR INFORMATION

A. Aging Report on Cases 18 Months and Older

V. REPORT ON STAFF ACTION ITEMS

VI. GOOD OF THE ORDER

(For information purposes only)

VII. ADJOURNMENT

***The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five (5) or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

****Although the meeting is scheduled for 9:00 a.m., it can start anytime thereafter, depending on the length of the Board of Retirement meeting. Please be on call.**

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.

Any documents subject to public disclosure that relate to an agenda item for an open session of the Committee, that are distributed to members of the Committee 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 Committee, at LACERA's offices at 300 North Lake Avenue, suite 820, Pasadena, California during normal business hours from 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 the Disability Retirement Services Division at 626-564-2419 from 7:30 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.

MINUTES OF THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
Board of Retirement**

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

GATEWAY PLAZA - 300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

Wednesday, September 6, 2017 1:48 P.M. – 2:03 P.M.

COMMITTEE MEMBERS

PRESENT:	Vivian H. Gray, Chair Marvin Adams, Vice Chair Ronald Okum David Muir, Alternate
ABSENT:	Alan Bernstein

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

Anthony Bravo
Keith Knox

STAFF, ADVISORS, PARTICIPANTS

JJ Popowich	Ricki Contreras	Maria Silva
Steven Rice	Vickie Neely	Jason Waller
Vincent Lim	Anna Kwan	Tamara Caldwell
Eugenia Der	Robert Hill	Ruby Minjares
Mike Herrera	Kerri Wilson	Barbara Tuncay
Allison E. Barrett	Mario Garrido	Justin Stewart
Frank Boyd	Marco Legaspi	Danny Hang
Angie Guererro	Marilu Bretado	Russell Lurina
Maria Muro	Thomas Wicke	Danny Hang
Michelle Yanes	Hernan Barrientos	Ricardo Salinas
Karla Sarni	Melena Sarkisian	

ATTORNEYS
Thomas J. Wicke

GUEST SPEAKER
None

The meeting was called to order by Chair Gray at 1:48 p.m.

I. APPROVAL OF THE MINUTES

A. Approval of minutes of the regular meeting of August 2, 2017

Mr. Adams made a motion, Ms. Gray seconded, to approve the minutes of the regular meeting of August 2, 2017. The motion passed unanimously.

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Release of Psychiatric/Psychological Medical Records to Unrepresented Applicants

Mr. Muir made a motion, Ms. Gray seconded, that the Disability Procedures & Services Committee return item to staff with the request to look into the issues associated with attorney's fees for the applicant if a court order is sought and is successful. The motion passed unanimously.

IV. FOR INFORMATION

V. REPORT ON STAFF ACTION ITEMS

VI. GOOD OF THE ORDER

Ms. Contreras asked Chair Gray if October 12, 2017 Disability Procedures and Services Committee meeting should be canceled due to joint meetings and lack of items. Ms. Gray stated it was okay to cancel Committee meeting for October 12, 2017.

VII. ADJOURNMENT

With no further business to come before the Disability Procedures and Services Committee, the meeting was adjourned at 2:03 p.m.

**The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five (5) or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.

October 23, 2017

To: Disability Procedures & Services Committee
Vivian H. Gray, Chair
Marvin Adams, Vice Chair
Alan Bernstein
Ronald Okum
David Muir, Alternate

From: Francis J. Boyd,
Senior Staff Counsel

For: November 9, 2017 Disability Procedures & Services Committee

Subject: **RELEASE OF PSYCHIATRIC/PSYCHOLOGICAL MEDICAL RECORDS TO UNREPRESENTED APPLICANTS**

RECOMMENDATION

That the Disability Procedures & Services Committee recommend to the Board of Retirement that it adopt the recommended policy statement contained in this memorandum regarding the release of psychiatric/psychological medical records to unrepresented applicants.

INTRODUCTION

The Disability Litigation Office has brought to my attention some concerns regarding the release of psychiatric medical records to applicants who are representing themselves in the disability retirement appeal process. While investigating their concerns, I came across documents referring to a Board policy prohibiting the release of psychiatric reports to unrepresented applicants without a court order. However, I was unable to locate an actual written policy adopted by the Board of Retirement. LACERA's current practice of withholding evidence at the appeal level raises due process issues that may be challenged in court. In my opinion, it is important that the Board establish a written policy that documents LACERA's positon on this issue.

This recommendation was presented to the Disability Procedures & Services Committee on September 6, 2017, and the Committee requested staff add language to the policy statement informing members that they may be entitled to attorney fees if they have to obtain a court order to release the requested psychiatric records. The Committee also requested that staff determine whether or not a member would be able to obtain their medical records and attorney fees through the Public Records Act. We

have addressed these requests and are now returning this matter back to the Committee.

LEGAL AUTHORITY

The Board of Retirement has the plenary authority and fiduciary responsibility to administer the retirement system, and it holds executive, legislative, and quasi-judicial powers. It has the sole authority to determine eligibility for a disability retirement. In administering its duties, the Board has the authority to promulgate rules, regulations, and policies.[1]

BACKGROUND

Roger M. Whitby, Principal Deputy County Counsel, Opinion Letter

In 1982, the Board of Retirement sought advice from the Office of County Counsel concerning the release of psychiatric reports to applicants whose disability applications were denied and who were representing themselves. On January 4, 1983, Roger M. Whitby, Principal Deputy County Counsel, provided an opinion letter to the Board on this issue wherein he expressed concerns about release of such information in light of the case of *Tarasoff v. Regents of University of California*.[2] In *Tarasoff*, a psychologist employed by the University of California, his superior, and the Regents of the University were held liable for the death of a girl who was killed by a man who had confided his intention to kill her to the psychologist. The California Supreme Court held that the psychologist had a duty to use reasonable care in warning the victim of the danger.

Mr. Whitby advised that, under *Tarasoff*, it was possible that a court might hold the Board of Retirement liable for injuries resulting from the release of a psychiatric report to an applicant where it was reasonably foreseeable that release of the report might result in the injury to the applicant or some other person. He then advised the following:

> . . . it is our advice that psychiatric reports should not be released to an applicant under circumstances where the therapist recommends against showing the report to the applicant and where the applicant has a history of violence, or where the therapist indicates that if the report is shown to the applicant, the applicant is likely to harm himself, the retirement staff, the therapist, or some other person.

Mr. Whitby stated that other than a situation where the therapist indicates that such harm or violence is likely to occur, the psychiatric reports would probably have to be shown to unsuccessful applicants in connection with their appeals, even if the therapist

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[1] Cal. Const., art. XVI, § 17, subd. (a) and (b); Gov. Code Sec. 31725; *Preciado v. County of Ventura, et al.* (1982) 143 Cal.App.3d 783, 789.
[2] *Tarasoff v. Regents of University of California* (1976) 17 Cal.3d 425.

has included some general boilerplate language to the effect that the report should not be shown to the applicant. Mr. Whitby added:

> We are concerned about the possible damaging psychological effects of allowing an applicant to review psychiatric reports relating to himself, as well as the effect of such a practice on your Board's ability to obtain candid reports from psychiatrists. However, we believe that the applicant's right to due process outweighs these considerations.

He then stated that "from a standpoint of protecting yourselves from liability, we believe that it is preferable to have a court order you to release a report rather than to have the court hold you liable for injuries resulting from releasing the report on your own volition."

October 5, 1983 Board of Retirement Meeting

On October 5, 1983, this matter came to the Board for a vote. The initial motion was to "withhold from applicants any information where a psychiatrist has specifically said that this information should not be disclosed to the applicant." However, several substitute motions were made and ultimately the issue was held over to the November 1983 meeting. The Board minutes from this meeting refer to an "existing Board policy with regard to the release of disability investigation packets to applicants acting in pro per who have been diagnosed as mentally or emotionally ill." I have been unable to locate such a policy. In reviewing the minutes for the meetings from November 1983 through November 1984, I was unable to confirm that the Board took any action on Mr. Whitby's opinion letter.

Disability Litigation Office Policy Regarding Release of Psychiatric Records to Unrepresented Applicants

Daniel McCoy, Chief Counsel of Disability Litigation from 1996 to 2007, authored Policies and Procedures of the LACERA Disability Litigation Office wherein he stated the following:

> It is the policy of the Board of Retirement, adopting the recommendation of the Office of the County Counsel, that psychiatric reports on an applicant's psychiatric evaluation are not to be given directly to the applicant without an order of a court.

Disability Litigation's policy states that reports may be given to the applicant's treating physician or to an attorney if the applicant gives, in writing, an unequivocal consent. It then explains:

> On occasion, the applicant has no treating physician and does not have an attorney. Implementation of the policy will, in effect, deny

> the applicant a fair hearing, which LACERA has a fiduciary duty to provide. In this kind of case, the record must [sic] reviewed for evidence supporting LACERA's refusal to provide the applicant with copies of psychiatric reports and records. Psychiatric reports favorable to the applicant's position will usually be evidence that supports LACERA's refusal to provide the applicant with copies of the psychiatric reports and records. However, this is not true in every case. Where the evidence favorable to the applicant's position does not support LACERA's refusal to provide copies of psychiatric reports and records to the applicant, and the applicant has been found by LACERA's consultant in psychiatry not to have a mental disorder, the record must be developed on whether there is a reasonable basis for LACERA's refusal to provide copies of psychiatric reports and records to the applicant. The attorney may ask LACERA's consultant in psychiatry whether allowing the applicant to have a [sic] copies of the psychiatric reports an [sic] records would create a risk of harm to the applicant or anyone else. If LACERA's consultant finds that there is no risk of harm, and there is no evidence to the contrary, the applicant *pro se* may be provided with a copy of the psychiatric report. If LACERA's consultant opines that there is a risk of harm, a copy of the report is not to be given directly to the applicant without a court order.

Mr. Whitby's January 4, 1983, opinion letter is included with the above policy statement.

LACERA Currently Does Not Release Psychiatric Medical Records to Pro Se Applicants

When an applicant appeals a denial decision by the Board of Retirement, Disability Retirement Services (DRS) sends the applicant a copy of the "Board Packet" which includes a copy of the panel physician's report(s). When the application involves a psychiatric or psychological condition and the applicant is not represented by counsel, the panel psychiatrist's report is not included in the packet and all references to the report in the Disability Retirement Evaluation Report are redacted. The applicant is notified that the panel psychiatrist's report is being withheld and that the report has been redacted. If an unrepresented applicant requests copies of all the medical evidence obtained by DRS, psychiatric records are not sent to the applicant and any reference to the psychiatric evidence is redacted. Any requests for a copy of the panel psychiatrist's report is handled by the Disability Litigation Office under its above-referenced policy.

LAW

Tarasoff v. Regents of University of California[3] is a 1976 decision which held that the parents of a murdered girl could state a cause of action against a psychologist and the hospital for which he worked when the psychologist failed to warn that his patient had threatened to kill the girl. It held that a special relationship between a doctor or psychotherapist and patient could support affirmative duties for the benefit of third persons.[4]

In *Hedlund v. Superior Court,*[5] a 1983 decision, the minor son of a woman shot by a psychologist's patient sued for emotional injuries suffered after the assailant's therapist failed to warn him of a known threat against his mother. The son, who was seated next to his mother when she was shot, asserted the therapist owed him a duty on the theory that it was foreseeable he would be injured if the patient's threats materialized.[6] The Supreme Court agreed. It held that a therapist's duty to warn potential victims of a patient's threatened violence extends "to persons in close relationship to the object of the patient's threat . . ."[7]

California Legislature Enacted Civil Code Section 43.92 in Response to the *Tarasoff* and *Hedlund* Decisions

County Counsel's 1983 opinion letter was written in the wake of the broad liability issues raised in the *Tarasoff* and *Hedlund* decisions. In reaction to these decisions, the Legislature in 1985 enacted California Civil Code section 43.92 which sharply limited the scope of liability for psychotherapists as defined by statute.[8] Section 43.92(a) states the following:

> There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to protect from a patient's threatened violent behavior or failing to predict and protect from a patient's violent behavior **except if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.** (Emphasis added.)

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[3] *Tarasoff v. Regents of University of California* (1976) 17 Cal.3d 425.
[4] *Id.* at p. 433.
[5] *Hedlund v. Superior Court* (1983) 34 Cal.3d 695.
[6] *Id.*at p. 705.
[7] *Id.* at p. 706.
[8] *Ewing v. Goldstein* (2004) 120 Cal.App.4th 807, 815.

Section 43.92 represents a legislative effort to strike an appropriate balance between conflicting policy interests—the need to preserve patient confidence and protecting the safety of someone whom the patient intends to harm.[9]

California Health & Safety Code Section 123115

California Health & Safety Code Section 123115(b) allows a health care provider to decline a patient's request to review or receive mental health records when the provider **"determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient."** Subsection (b)(1) requires the health care provider to explain the reasons for refusing to permit inspection or provide copies of the records, including a "description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted."

Health Insurance Portability and Accountability Act (HIPAA)

Under statutory authority from the Federal Health Insurance Portability and Accountability Act, the Secretary of the Department of Health and Human Services promulgated regulations to protect the privacy of medical records. 45 C.F.R. Section 164.524 sets forth an individual's right of access to protected health information. This regulation allows for a medical provider to deny access to the medical records if the provider determines **"that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person."** [10] While LACERA has been advised by outside counsel that the organization's disability operations are not subject to HIPAA, it is relevant to consider its provisions as guidance in drafting policy.

The California Public Records Act

The California Public Records Act (Gov. Code §§ 6250 et seq.) was intended to safeguard the accountability of government to the public. To this end, the act makes public access to government records a fundamental right of citizenship. Implicit in the democratic process is the notion that government should be accountable for its actions and, in order to verify accountability, individuals must have access to government files. Such access permits checks against the arbitrary exercise of official power and secrecy in the political process. However, a narrower but no less important interest is the privacy of individuals whose personal affairs are recorded in government files.[11]

- **Medical records are exempt from the Public Records Act**

Under Government Code section 6254(c) personnel and medical records are exempt.

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[9] *Ewing v. Goldstein, supra,* 120 Cal.App.4th, 807, 816.
[10] 45 C.F.R. 164.524(a)(3)(i) (Emphasis added.)
[11] *Rogers v. Superior Court* (1993) 19 Cal. App. 4th 469.

The proposed policy statement outlined below pertains to unrepresented applicants' requests for records during an administrative proceeding governed by CERL. Given the nature of the administrative proceeding and the medical-record exemption under Section 6254(c), it is the opinion of the Legal Office that the Public Records Act is not applicable.

Attorney Fees

- **CERL**

Government Code section 31536 states the following:

> If a superior court reverses the denial by the board of an application for a retirement allowance, or for a survivor's allowance based on such allowance, **or for a claim based on a claimed pension right or benefit**, the superior court **in its discretion** may award reasonable attorney's fees as costs to the member or beneficiary of the member who successfully appealed the denial of such application. Such costs shall be assessed against the board, shall be considered a cost of administration, and shall in no event become a personal liability of any member of the board. (Emphasis added.)

In the event the applicant successfully obtains a court order for LACERA to release psychiatric/psychological records and/or reports, an applicant may be entitled to attorney fees and costs under Section 31536.

DISCUSSION

I have been unable to locate a Board-adopted policy regarding the release of psychiatric medical records to applicants representing themselves. In practice, LACERA does not release psychiatric reports and records to applicants without a court order. It appears that the only written policy related to this issue is the Disability Litigation Office's policy which is based on the January 4, 1983 County Counsel opinion letter. As noted above, there have been changes in the law since this opinion was authored, so it is my recommendation that the Board adopt an updated policy.

It is important for this Committee to understand that California Civil Code section 43.92, California Health & Safety Code section 123115, and the HIPAA statutes discussed above place the responsibility of determining whether or not it is safe for patients to have access to their psychiatric records on the medical provider. The common denominator in these statutes is whether or not access to the records poses a substantial risk of significant adverse or detrimental consequences to the patient or another person. While LACERA is not a medical provider, these statutes provide perspective in determining LACERA's policy on this issue.

In an appeal of a disability retirement decision, LACERA owes its members due process, and access to the report(s) upon which the Board based its decision is crucial for members to move forward in their appeals. The Board's policy must strike a balance between ensuring due process and the potential safety concerns involved in releasing psychiatric medical records.

RECOMMENDED POLICY STATEMENT

Considering these issues, it is my recommendation that the Board of Retirement adopt the following policy addressing the release of LACERA's panel psychiatrist's/psychologist's report and the psychiatric/psychological records obtained by DRS during its investigation:

> **Release of Psychiatric/Psychological Records/Reports Policy**
>
> It is the policy of the Board of Retirement, that psychiatric/psychological reports and/or psychiatric/psychological records are not to be given directly to the applicant without confirmation from the authoring psychiatrist, psychologist, or therapist that release of the report or records does not pose a substantial risk of significant adverse or detrimental consequences to the applicant or another person. Psychiatric/psychological records and**/or** reports will be given to the applicant with a court order. **In the event the applicant successfully obtains a court order for LACERA to release psychiatric/psychological records and/or reports, an applicant may be entitled to attorney fees and costs pursuant to Government Code section 31536.***

* Language in bold text has been added to the above statement to show the Committee the language that was added subsequent to the September 6, 2017 meeting. This language will not appear in bold text in the actual policy statement.

It is recommended that the implementation of this policy be handled in the following manner:

- **Release of LACERA's Panel Psychiatrist/Psychologist Report**

When an applicant has appealed the Board's decision on a psychiatric/psychological claim and is not represented by an attorney, Disability Retirement Services will obtain a statement from LACERA's panel psychiatrist/psychologist stating whether or not the release of the report to the applicant would pose a substantial risk of significant adverse or detrimental consequences to the patient or another person. The physician will be required to explain the specific reasons for withholding the report. (This question could

be incorporated into the panel physician guidelines which would provide instruction to DRS as to how to handle the matter at the time the appeal is received.)

- **Release of Psychiatric/Psychological Records Obtained by Disability Retirement Services During Its Investigation**

When an unrepresented applicant who has appealed the Board's decision on a psychiatric/psychological claim requests copies of the medical records obtained during the investigation of the application, Disability Retirement Services will not release any psychiatric or psychological records until it receives confirmation from the authoring doctor that the release of the report or records to the applicant does not pose a substantial risk of significant adverse or detrimental consequences to the patient or another person.

- **Notification of the Applicant's Right to Obtain a Court Order**

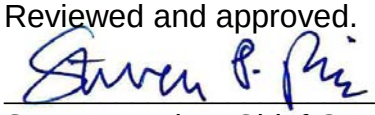
In the event LACERA denies an unrepresented applicant access to his or her psychiatric/psychological records/reports based on the above policy, LACERA will notify the applicant of his or her right to obtain a court order for these records.

CONCLUSION

In an appeal of a disability retirement decision, LACERA owes its applicants due process, and access to the report(s) upon which the Board based its decision is crucial for applicants to move forward in their appeals. However, public policy necessitates consideration of the potential safety concerns involved in releasing psychiatric/psychological medical records. It is important that the Board establish a written policy that documents LACERA's positon on this issue.

I therefore recommend that the Disability Procedures & Services Committee recommend to the Board of Retirement that it adopt the policy statement, as described above, addressing the release of psychiatric/psychological medical records to unrepresented applicants.

Reviewed and approved.



Steven P. Rice, Chief Counsel

c: Each Member, Board of Retirement

October 27, 2017

To: Disability Procedures & Services Committee
Vivian H. Gray, Chair
Marvin Adams, Vice Chair
Alan Bernstein
Ronald Okum
David Muir, Alternate

From: Francis J. Boyd,
Senior Staff Counsel

For: November 9, 2017 Disability Procedures & Services Committee

Subject: ***PROPOSED* PANEL PHYSICIAN GUIDELINES**

RECOMMENDATION

That the Disability Procedures & Services Committee recommend to the Board of Retirement that it revise its current Panel Physician Guidelines for Evaluating Members for Disability Retirement and adopt the *Proposed* Panel Physician Guidelines as described below.

INTRODUCTION

Ricki Contreras, Division Manager, Disability Retirement Services, and I have had a number of discussions about streamlining the processing of members' applications for disability retirement. One factor slowing down the application process is the need to obtain supplemental medical reports from our panel physicians because some reports do not provide sufficient information for the Board of Retirement to make a decision on the application. As we discussed this issue, we identified some problems with the questions included in our current Panel Physician Guidelines that contribute to the need for supplemental reports. We therefore have made some adjustments to the guideline questions which are described below.

In addition to limiting the need for supplemental reports, the questions contained in the *Proposed* Panel Physician Guidelines are designed to elicit more information from the panel physician for the Board of Retirement to weigh and consider in determining an applicant's eligibility for a disability retirement.

LEGAL AUTHORITY

The Board of Retirement has the plenary authority and fiduciary responsibility to administer the retirement system, and it holds executive, legislative, and quasi-judicial powers. It has the sole authority to determine eligibility for a disability retirement. In administering its duties, the Board has the authority to promulgate rules, regulations, and policies.[1]

BACKGROUND

Questions contained in the current Panel Physician Guidelines

The current Panel Physician Guidelines request that panel physicians respond to the following questions:

(1) Is the applicant capable of performing each of the duties described in the Class Specification for the applicant's occupation?

(2) Is the applicant substantially able to perform the usual duties of his or her actual assignment?

In this regard, an employee may not be able to perform each and every duty within the job classification, yet still be capable of **substantially performing the usual duties**. If an employee cannot substantially perform the usual duties of the job and the condition is permanent in terms of recovery, that employee is incapacitated under Retirement Law.

A disability is considered "permanent" when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment.

a) If the employee is **permanently incapacitated**, the physician must describe which duties of the job the employee cannot perform and why the employee cannot perform them.

b) Was the employee permanently incapacitated **at the time** he/she **left County service**?

[1] Cal. Const., art. XVI, § 17, subd. (a) and (b); Gov. Code Sec. 31725; *Preciado v. County of Ventura, et al.* (1982) 143 Cal.App.3d 783, 789.

c) If the employee is **not** permanently incapacitated, the physician must state why the employee, despite his/her claim for disability, can perform the job.

(3) Did the Applicant's employment play a role in any injury or illness that the Applicant claims to cause incapacity for duty?

If so, please state in detail how the job or job environment including industrial factors caused, aggravated, lighted up, or contributed to the condition(s) including a summary of all supportive facts. The Board will determine from your opinion whether the role was real and measurable.

A copy of the current Panel Physician Guidelines is attached to this memorandum.

Problems identified in our current Panel Physician Guidelines

- **Compound questions contained in our current Panel Physician Guidelines lead to incomplete responses and a need to obtain supplemental reports.**

Currently, we request our panel physicians to respond to three primary questions:

1) Is the applicant capable of performing each of the duties described in the Class Specification for the applicant's occupation?
2) Is the applicant substantially able to perform the usual duties of his or her actual assignment?
3) Did the Applicant's employment play a role in any injury or illness that the Applicant claims to cause incapacity for duty?

However, questions 2 and 3 contain a number of follow-up questions. At times, a panel physician will respond to the primary question and overlook the follow-up questions, necessitating the need for a supplemental report. One important follow-up question that is often overlooked by our panel physicians is whether or not the employment aggravated or accelerated the underlying medical condition causing the incapacity. The *Proposed* Panel Physician Guidelines listed below break up the follow-up questions into separate, distinct questions. This change combined with the requirement that the doctor repeat each question in their report, will obligate the doctor to provide the requested information in a timely manner.

- **The ability to perform each of the duties described in the Class Specification is not a requirement for a disability retirement under CERL.**

Entitlement to a disability retirement is established when members are permanently incapacitated for the performance of their usual duties, not each of the duties in the Job

Classification.[2] Question number one of our current Panel Physician Guidelines asks whether or not the applicant is capable of performing each of the duties listed in the Class Specification. Including this question on the Panel Physician Guidelines sometimes confuses the doctor resulting in an unclear report addressing the pertinent issue: whether applicants are capable of performing their *usual duties*. For this reason, this question has been eliminated from the *Proposed* Panel Physician Guidelines listed below.

PROPOSED **PANEL PHYSICIAN GUIDELINES**

In order to give the panel physician some context, the *Proposed* Panel Physician Guidelines provide a brief description of the Board of Retirement's and the doctor's roles in the application process. Thereafter, the doctor is provided with a brief summary of the standards for incapacity, permanency, service connection, as well as a comparison of retirement law versus workers' compensation law. The panel physician is then asked to respond to the following questions:

1. Is the applicant substantially able to perform the usual duties of his or her actual assignment as described in the Disability Retirement Evaluation Report? Please explain your opinion.

2. Please describe which duties the applicant can and cannot perform and explain why the duties can or cannot be performed. Please explain your opinion.

3. Is the applicant's current incapacity permanent? Please explain your opinion.

   A disability is considered "permanent" when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment.

4. Was the applicant continuously incapacitated from the date he or she last worked to the date the disability retirement application was filed? If in your opinion the applicant became incapacitated after he or she last worked, please state when the incapacity began. Please explain how the medical records support your conclusion.

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[2] Government Code section 31720; *Lindsay v. County of San Diego Retirement Board* (1964) 231 Cal.App.2d 156, 160; *Glover v. Board of Retirement* (1989) 214 Cal.App.3d 1327, 1332; *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876; *Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 694-696; *Schrier v. San Mateo County Employees' Ret. Ass'n* (1983) 142 Cal.App.3d 957, 961-962.

5. Based on your evaluation and medical history, please state what **work restrictions**, **if any**, (*including prophylactic*) you would recommend for the applicant. Please explain your opinion.

   Please avoid using words like prolonged, light, heavy, frequent, occasional, and repetitive in any of your recommended work restrictions. Instead, provide weight limitations in pounds/ounces and time limits in terms of consecutive hours/minutes as well as total hours/minutes in a defined workday. Also, please include length of any required breaks.

6. Did the applicant's employment play a role in any injury or illness that the applicant *claims* to cause incapacity? If yes, please explain how the employment played a role in applicant's *claimed* incapacitating medical condition. **Please respond to this question even if it is your opinion that the injury or illness does not prevent the applicant from performing his or her duties.**

7. Did the employment cause any permanent aggravation and/or acceleration of any medical condition limiting the applicant's ability to perform his or her job? Please explain your opinion.

8. If it is your opinion that the applicant is permanently incapacitated for nonservice-connected reasons, please explain what factors led to the applicant's incapacitating medical condition.

A copy of the *Proposed* Panel Physician Guidelines is attached to this memorandum.

- **Explanation of Changes**

Question 1:

In the above proposed questions, the panel physician is first asked to provide an opinion as to whether or not the applicant is capable of substantially performing his or her actual assignment as described in the Disability Retirement Evaluation Report. The response to this question will provide the Board of Retirement with a medical conclusion on the relevant issue of incapacity.

Question 2:

Question two goes a step further and requests that the doctor describe the specific duties that can and cannot be performed. This information will provide the Board of Retirement, as the trier of fact, with more information to make the determination as to whether or not the applicant is in fact *substantially* able to perform the usual duties of the job.

Question 3:

Question three is a separate, distinct question asking the doctor whether or not the applicant's incapacity is permanent. Currently this question is included in a follow-up question and is sometimes overlooked by the doctor.

Question 4:

Question four asks the doctor whether or not the applicant was *continuously* incapacitated from the date last worked to the date the disability retirement application was filed. This question is designed for applications filed more than four months after the applicant discontinued service. Having this information on hand will allow staff and the Board of Retirement to determine whether the application is filed timely under Government Code section 31722 without having to go back to the doctor for a supplemental report.

Question 5:

Oftentimes, it is necessary for staff to obtain a supplemental report addressing work restrictions—this slows down the application process. Requesting this information up front will speed up the process and provide the Board of Retirement more information to make the determination as to whether or not the applicant is *substantially* able to perform the usual duties of the job.

Question 6:

Question 6 asks the doctor whether or not the employment played a role in any injury or illness that the applicant claims to cause incapacity. This is the question contained in our current Panel Physician Guidelines. The Committee may notice that question refers to an injury or illness that the applicant *claims* to cause incapacity. This phrasing requires the doctor to address causation even if the doctor opines the applicant is not incapacitated. At times, a doctor will conclude that the applicant is able to perform the usual duties of the job but issue work restrictions that cannot be accommodated by the department. Requiring the doctor to address causation even if he or she opines the applicant is not incapacitated, saves staff from having to go back to the doctor to obtain an opinion on causation.

Question 7:

Question 7 requires the doctor to explain whether or not the employment caused any permanent aggravation and/or acceleration of any medical condition limiting the applicant's ability to perform his or her duties. Currently, this question is included in a follow-up question and is sometimes overlooked by the doctor.

Question 8:

In situations where the doctor finds an applicant incapacitated for nonservice-connected reasons, question 8 requires the doctor to explain how he or she came to this conclusion. The doctor's response to this question will provide more information to the Board of Retirement so that it can fulfill its role as the trier of fact.

- **Implementation of *Proposed* Panel Physician Guidelines**

It is important that our panel physicians have a clear understanding of the changes in the Panel Physician Guidelines. Written notification of the changes and instructions will be sent to each panel physician. In addition, Disability Retirement Services (DRS) has had a discussion with Communications about preparing a short instructional video for the doctors. DRS and Legal will also be available to respond to any questions that the panel physicians may have.

CONCLUSION

Disability Retirement Services and the Legal Office believe that the above-proposed changes to the Panel Physician Guidelines will streamline the processing of our members' applications for disability retirement. In addition, the proposed changes will elicit more information from the panel physician for the Board of Retirement to weigh and consider in determining an applicant's eligibility for a disability retirement.

I therefore recommend that the Disability Procedures & Services Committee recommend to the Board of Retirement that it review and adopt the *Proposed* Panel Physician Guidelines.

Reviewed and approved.

Steven P. Rice, Chief Counsel

Attachments

c: Each Member, Board of Retirement

PROPOSED PANEL PHYSICIAN GUIDELINES

LACERA Board of Retirement

The Los Angeles County Employees Retirement Association's Board of Retirement is a body created pursuant to the County Employees Retirement Law of 1937 (Government Code section 31450, et seq.). Among the Board's statutory duties is determining when members of the Retirement Association are eligible for disability retirement under the standards set forth in the Retirement Law. In making those determinations, the Board is bound to act consistently with its fiduciary nature—that is, in a way worthy of the trust and confidence reposed in the Board by the members of the Retirement Association. The Board's fiduciary duties extend both to the individual members of the Association, and to the membership of the Association as a whole. The duty to individual members includes the obligation to grant a disability retirement when the applicant has met all of the conditions specified in the Retirement Law. The duty to the Association as a whole includes the obligation to safeguard the Association's assets by denying a disability retirement when the applicant has not met all of the legal requisites.

Your Role in this Process

The determination of whether the applicant is entitled to disability retirement benefits is ultimately made by the Board of Retirement. To determine entitlement, the Board considers a variety of pertinent information, including your expert opinion on the medical-legal aspects of this matter. The Board requests that you (1) review the attached medical, employment, and relevant records; (2) perform a comprehensive medical examination; and (3) provide a written forensic report answering specific medical-legal questions posed by LACERA.

The Board of Retirement's decision must be based upon substantial evidence. In determining whether a medical opinion is substantial evidence, the courts have explained that the value of a medical opinion is not found simply in the physician's conclusion, but it lies on the facts on which the opinion is based and in the reasoning by which the physician progresses from the facts to the conclusion. We therefore request that you explain how the medical records and facts support your conclusion.

The Retirement Association is equally well served by a grant or a denial of benefits where the decision to do so is based on sound medical-legal conclusions. In that respect, you have not been retained for the purpose of reaching any particular conclusion, and you are expected to exercise neutral and independent judgment in evaluating the applicant's medical condition. With that standard of independence in mind, you are asked to prepare a written report that may be reviewed by staff members, referees, Board members and judicial officers who do not share your background as a medical professional. If possible, please state your opinions in lay terms with an explanation of the facts and reasoning supporting your conclusion.

COUNTY EMPLOYEES RETIREMENT LAW (CERL)
DISABILITY RETIREMENT STANDARDS

To assist you in answering the specific questions posed below, the following is a brief description of some of the legal concepts applicable to disability retirement proceedings:

STANDARD FOR INCAPACITY

Incapacitated: Under disability retirement law, an applicant is incapacitated, physically or mentally, if the applicant is substantially unable to perform their usual job duties. Usual job duties are duties frequently performed, as opposed to duties performed rarely or duties that the employer does not actually require to be performed. Incapacity does not require an inability to perform all the duties listed in the Job Classification. As to a particular duty, an applicant is incapacitated from performing that duty if:

(1) it is not physically possible for the applicant to perform the activity at all, or

(2) even if it is possible for the applicant to perform the duty for a period of time, it is **medically probable** that performance of the duty will cause further injury.

(3) Pain is not incapacitating if an applicant is able to actually perform the activity, even if performing it would cause some pain or discomfort, cause fear of further injury and/or**,** create some risk of future injury that is less than probable; however, pain can be a factor contributing to a finding of incapacity where it is **probable** that performance of the duty in question would cause pain sufficiently severe to make **performance of the duty impossible or exceedingly difficult.**

STANDARD FOR PERMANENCY

Permanent: An incapacity **is permanent** when further change in an applicant's medical condition is not medically probable.

Not Permanent: An incapacity **is not permanent** where:

- There is a medical probability that further conventional medical treatment reasonably available to the applicant will bring about a positive material change in the applicant's medical condition, without unreasonable risk to the applicant, which enables him to perform his duties.
- An applicant may not meet the permanency standard, if his refusal to accept further treatment is determined by medical opinion to be unreasonable. An applicant's refusal is usually found to be unreasonable where the medical treatment has minimal risk and it is likely to improve the applicant's condition to the point where he can perform his duties. An applicant's refusal is usually found to be reasonable where the medical treatment has substantial risk, and/or where it is not likely to significantly improve the applicant's condition, or where the applicant has bona fide religious beliefs or a medical condition that interferes with pursuit of the treatment.

STANDARD FOR SERVICE CONNECTION (industrial causation)

You are also asked to express an opinion as to whether the applicant's medical condition is service connected (industrial). Some standards for determining whether a permanent incapacity is service connected are as follows:

Service Connection:

- County employment need not be the sole cause of the incapacity, but it must make a substantial contribution to the incapacity.

- County employment is considered a substantial contribution to an applicant's incapacity where there is a real and measurable link between the County employment and the applicant's incapacity. The employment must be of some real and measurable consequence to the incapacity.

- An infinitesimal or inconsequential connection between employment and disability is not real and measurable.

- Service connection is established where the employment permanently aggravates or accelerates the underlying pathology of a pre-existing condition causing an applicant to be disabled at an earlier time than if he had not worked for the County.

Nonservice connection:

- Service connection is not found when the County employment merely causes a temporary aggravation and/or exacerbation of symptoms.

- Service connection is not found when the County employment has not played an active role in the development of the incapacity; that is, the County employment has merely been a passive stage for the natural progression of a non-industrial condition.

- Industrial causation is not proven, if there is no identifiable mechanism of injury to establish a real and measurable link between the employment and the incapacity or if reaching such a conclusion would involve speculation.

Comparison of Retirement Law and Workers' Compensation

In evaluating the applicant, please be aware of the fact that establishing "permanent incapacity" under the Retirement Law is not the same as establishing "permanent disability" under the Workers' Compensation Law. "Permanent Disability" under Workers' Compensation Law is a permanent injury that impairs a worker's earning capacity or a worker's bodily function, or that creates a competitive handicap for the worker in the open labor market.

Under disability retirement law, "permanent incapacity" for the performance of duty is the substantial inability of an applicant to perform his or her usual duties. An applicant may have a

permanent disability under the Workers' Compensation Law and not be incapacitated from duty under the disability retirement law. Similarly, a worker may be incapacitated from performing the particular duties of the applicant's position in County service even though the applicant is able to perform other jobs in the open labor market.

Your Report

Your written report should contain discussion of the items listed below, as well as a discussion of the specific medical-legal questions set forth at the end of this letter.

Please note the opinion you provide LACERA is restricted to matters within your specialty. However, you may identify medical conditions outside your specialty that you believe may need medical attention.

Job Description	Please include your description of the applicant's usual job duties and its requirements. Please use the description provided by LACERA staff in the Disability Retirement Evaluation Report.
History of Injury/Illness	Include a summary of the applicant's medical history pertaining to the subject injury or illness and the source(s) of that information.
Applicant's Complaints	Based on your interview of the applicant, please provide a discussion of the applicant's current complaints relevant to the conditions the applicant applied for disability retirement.
Description of Examination	Examination Protocol requires an explanation of tests conducted, if any, and statement of findings, including a discussion of your objective findings upon examination. Findings should explain how the medical evidence supports your conclusions. Please include the applicant's height and weight in your report.
Medical History	Please provide a review of applicant's medical history and prior injuries/illness.
Review of Records	Your report should include a comprehensive summary of all the pertinent records sent to you by LACERA.
Diagnostic Impression	Please provide a discussion of your impression/diagnoses.
Contrary Opinions	Include a statement of why you do not accept the contrary opinions of other physicians.

Finally, please answer **ALL** Medical – Legal Questions posed below. **Your report should first restate each question and then provide a response.**

MEDICAL – LEGAL QUESTIONS

1. Is the applicant substantially able to perform the usual duties of his or her actual assignment as described in the Disability Retirement Evaluation Report? Please explain your opinion.

2. Please describe which duties the applicant can and cannot perform and explain why the duties can or cannot be performed. Please explain your opinion.

3. Is the applicant's current incapacity permanent? Please explain your opinion.

   A disability is considered "permanent" when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized and unlikely to change substantially with our without medical treatment.

4. Was the applicant continuously incapacitated from the date he or she last worked to the date the disability retirement application was filed? If in your opinion the applicant became incapacitated after he or she last worked, please state when the incapacity began. Please explain how the medical records support your conclusion.

5. Based on your evaluation and medical history, please state what **work restrictions, if any,** *(including prophylactic*) you would recommend for the applicant. Please explain your opinion.

   Please avoid using words like prolonged, light, heavy, frequent, occasional, and repetitive in any of your recommended work restrictions. Instead, provide weight limitations in pounds/ounces and time limits in terms of consecutive hours/minutes as well as total hours/minutes in a defined workday. Also, please include length of any required breaks.

6. Did the applicant's employment play a role in any injury or illness that the applicant *claims* to cause incapacity? If yes, please explain how the employment played a role in applicant's *claimed* incapacitating medical condition. **Please respond to this question even if it is your opinion that the injury or illness does not prevent the applicant from performing his or her duties.**

7. Did the employment cause any permanent aggravation and/or acceleration of any medical condition limiting the applicant's ability to perform his or her job? Please explain your opinion.

8. If it is your opinion that the applicant is permanently incapacitated for nonservice-connected reasons, please explain what factors led to the applicant's incapacitating medical condition.

Your evaluation must be based on:

- Your examination of the applicant
- Your review of the Job Description in the Disability Retirement Evaluation Report and/or Class Specification/Job Analysis, if available
- Your review of the medical records and relevant records provided
- The information provided in the Disability Retirement Evaluation Report, prepared by LACERA staff.

If LACERA receives a panel physician report that is unclear, does not justify the conclusions, or does not follow the panel physician guidelines, a supplemental report may be requested. **The supplemental report will be prepared at the expense of the panel physician.**

Your report is privileged and confidential and should not be released to any person or entity under any circumstances – even if subpoenaed – without authorization from this office.

LACERA Los Angeles County Employees Retirement Association
300 N. Lake Ave., Pasadena, CA 91101 / PO Box 7060, Pasadena, CA 91109-7060 / www.lacera.com / 626/564-6000

PANEL PHYSICIAN GUIDELINES FOR EVALUATING MEMBERS FOR DISABILITY RETIREMENT (Please review before completing your report)

The Board of Retirement relies heavily upon the report by its panel physician to make a finding on applications for disability retirement. You are requested to provide the Board with your opinions, and the reasons for your opinions, on the following questions:

(1) Is the applicant capable of performing each of the duties described in the Class Specification for the applicant's occupation?

(2) Is the applicant substantially able to perform the usual duties of his or her actual assignment?

In this regard, an employee may not be able to perform each and every duty within the job classification, yet still be capable of **substantially performing the usual duties.** If an employee cannot substantially perform the usual duties of the job and the condition is permanent in terms of recovery, that employee is incapacitated under Retirement Law.

A disability is considered "permanent" when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment.

a) If the employee is **permanently incapacitated**, the physician must describe which duties of the job the employee cannot perform and why the employee cannot perform them.

b) Was the employee permanently incapacitated **at the time** he/she **left County service**?

c) If the employee is **not** permanently incapacitated, the physician must state why the employee, despite his/her claim for disability, can perform the job.

(3) Did the Applicant's employment play a role in any injury or illness that the Applicant claims to cause incapacity for duty?

If so, please state in detail how the job or job environment including industrial factors caused, aggravated, lighted up, or contributed to the condition(s) including a summary of all supportive facts. The Board will determine from your opinion whether the role was real and measurable.

Your evaluation must be based on:

- Your examination of the applicant
- Your review of the Class Specification and the Job Analysis, if available
- Your exam with the applicant to determine the actual and usual job duties and the physical requirements of the job
- Your review of the medical records
- The information provided in the Disability Retirement Evaluation Report, prepared by LACERA staff.

Note: The applicant has been instructed NOT to bring any records to the medical appointment. Should the applicant do so, please do not review them. The correct procedure is to direct the applicant to forward these documents to the Disability Retirement Specialist

assigned to his or her case. The documents will be recorded and sent to you for review. This procedure is necessary should the case go to appeal.

The opinion you provide LACERA is restricted to matters within your specialty.

However, you may identify medical conditions outside of your specialty that you believe need medical attention.

The report should include at least the following sections:

I. **Job Description** – Your description of the applicant's job duties and its requirements.
II. **History of Injury/Illness**
III. **Applicant's Complaints** – Must be based on your interview of the applicant.
IV. **Description of Examination** – Examination protocol, explanation of tests conducted, if any, and statement of findings. Include the member's height and weight in your report.
V. **Medical History** – Review of applicant's medical history and prior injuries/illnesses.
VI. **Review of Records**
VII. **Diagnostic Impression**
VIII. **Conclusions** - Present your answers to the question of whether the applicant is incapacitated and, if so, whether the incapacity is service-connected. Include the data on which you rely and the reasoning by which you progress to your conclusions.
IX. **Contrary Opinions** – Include a statement of why you do not accept the contrary opinions of other physicians.

If LACERA receives a panel's physician's report that is unclear or does not justify the conclusions, a supplemental report may be requested.

ATTENTION MEDICAL STAFF: If any psychiatrist on our panel orders a MMPI-2 test, it should be sent to Caldwell Reports for interpretation. When Caldwell interprets the test, a copy will be sent to LACERA and the requesting physician.

All Panel Physicians: Please order MRI, CT, and selected other diagnostic imaging services through Magnetic Imaging Services, Inc. LACERA's evaluating physician should contact LACERA's case investigator/Disability Retirement Specialist for scheduling and processing. If you have any questions or need additional information, contact LACERA's Disability Retirement Services Division at **(626) 564-2419.**

October 23, 2017

TO: Disability Procedures & Services Committee
Vivian H. Gray, Chair
Marvin Adams, Vice Chair
Alan Bernstein
Ronald Okum
David Muir, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: November 9, 2017, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF FRANK GUELLICH, M.D., AS A LACERA PANEL PHYSICIAN**

On August 24, 2017, Debbie Semnanian and Barbara Tuncay interviewed Frank Guellich, 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 Frank Guellich, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJ:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

October 27, 2017

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

FROM: **Debbie Semnanian** D.S.
Disability Retirement Specialist Supervisor

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

On August 24, 2017, Barbara Tuncay, Acting Supervisor, Disability Retirement Services, and I interviewed **Frank Guellich, M.D.** at his office, which is located at 237 N. Riverside Avenue, Rialto, CA 92376. The office is located in a former one-story residence in a mixed residential/commercial area with free parking behind the building and on the street in front of the office.

Dr. Guellich is a Board Certified orthopedist and has been in private practice for over thirty years. Dr. Guellich's office has four examination rooms. He estimates that 20 percent of his practice is devoted to patient treatment, while the other 80 percent of his time is devoted to IME evaluations for other retirement systems and workers' compensation. Dr. Guellich shares office space with Gabriel Favella, M.D., an internist, and Vinicio Cornejo, D.C.

As referenced in his Curriculum Vitae, Dr. Guellich graduated from New Jersey College of Medicine & Dentistry with his Medical Degree in 1967. He completed an internship at Robert Packer Hospital, Sayre, Pennsylvania, a General Surgery residency at Cooper Hospital in New Jersey, and an orthopedic residency at National Orthopedic and Rehabilitation facility in Arlington, VA. Dr. Guellich completed a Hand Fellowship at Columbia Presbyterian Medical Center in New York. From July 1973 until June 1985, Dr. Guellich served in the U.S. Army at Valley Forge Army Hospital in Phoenixville, PA. He is a Vietnam Veteran and retired military.

The office was clean with ample seating. A handicap accessible restroom is located within the office. Dr. Guellich has an office staff of two office personnel.

Staff reviewed the LACERA Disability Retirement procedures and expectations in its evaluation of County Employees applying for both service connected and non-service 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. Guellich 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. Guellich agreed to adhere to LACERA's standard of having his evaluation reports sent to us within 30 days of examination. Staff confirmed that Dr. Guellich is agreeable with accepting payment pursuant to LACERA's contract and billing procedures. Dr. Guellich 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 has also been advised of the requirement to immediately notify LACERA if any license, Board Certification, or insurance coverage is lapsed, suspended or revoked. He was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit.

RECOMMENDATION

Based on our interview and the need for his specialty in this particular geographic location, staff recommends that Dr. Guellich's application be presented to the Board of Retirement for approval as a LACERA Panel Physician.

DS:mb

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 02/24/2017
Group Name: Consultative Examination Services, Inc		Physician Name: Frank Guellich, M D	
I. Primary Address:	725 W Hollyvale Street, Azusa, CA 91702 (mailing and remittance address only)		
Contact Person	Moses Hernandez	Title	Chief Operating Officer
Telephone:	(626) 513-0719	Fax	(626) 513-4095
II. Secondary Address	237 N Riverside Avenue, Rialto CA 92376 (for patient evaluation)		
Contact Person	Moses Hernandez	Title	Chief Operating Officer
Telephone	(626) 513-0415	Fax	(626) 513-4095

PHYSICIAN BACKGROUND			
Field of Specialty	Orthopaedic Surgery	Subspecialty	Hand Surgery
Board Certification ☒ Yes ☐ No	License # G53695	Expiration Date	06/30/2018

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

Evaluation Type

I. Workers' Compensation Evaluations
- ☒ Defense How Long? 4 yrs.
- ☒ Applicant How Long? 2 yrs
- ☐ AME How Long? _____
- ☒ IME How Long? 4 yrs
- ☐ QME How Long? _____

II. ☒ Disability Evaluations How Long? 4 yrs

For What Public or Private Organizations? CalPERS, OCERS, ICERS, SBCERA

Currently Treating? ☒ Yes ☐ No

Time Devoted to: Treatment 20 % Evaluations 80 %

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:

Moses Hernandez (Please Print Name) Title: Chief Operating Officer

Physician Signature: [signature] Date: 2/24/17

FOR OFFICE USE ONLY
Physician Interview and Sight Inspection Schedule

Interview Date: 8/24/17	Interview Time: 10:00 A.M
Interviewer: Debbie Inmanian and Barbara Tuncay	

CURRICULUM VITAE

Frank G. Guellich, M.D.

Diplomate, American Board of Orthopaedic Surgery

Experience:	09/1961-06/1966	New Jersey College of Medicine & Dentistry Newark, NJ **M.D. DEGREE**
	07/1966-06/1967	Robert Packer Hospital Sayre, PA **INTERNSHIP**
	07/1967-06/1968	Cooper Hospital Camden, NJ **GENERAL SURGERY RESIDENT**
	07/1968-06/1971	National Orthopedic and Rehabilitation Arlington, VA **ORTHOPEDIC RESIDENT**
	07/1971-06/1973	U.S. Army Valley Forge Army Hospital Phoenixville, PA **MAJOR U.S. ARMY-ORTHOPEDIC CARE FOR VIETNAM CASUALTIES**
	07/1973-09/1985	Private Practice Hackettstown Adventist Hospital Hackettstown, NJ **ATTENDING-PRIVATE PRACTICE**
	07/1983-06/1984	Columbia Presbyterian Medical Center New York, NY **HAND FELLOWSHIP**
	11/1985-11/1992	Medico-Legal Practice California NO LONGER IN BUSINESS
	12/1992 – 12/2010	Columbia University-Harlem Hospital New York, NY **ASSISTANT PROFESSOR ORTHOPEDIC SURGERY LEVEL 1 TRAUMA CENTER**

Experience:	01/1998-2007	New York Police Department Jamaica-Queens Medical Division **DISABILITY EVALUATION FOR INJURED POLICE FORCE MEMBERS**
	01/2011-10/2011	During this period of time I went through the processes of obtaining privileges at both Kaiser Permanente and El Camino Hospital in Mountain View, CA
	10/2011-02/2012	Kaiser Permanente Riverside, CA **HOSPITAL ORTHOPEDIC CLINIC STAFF**
	2012-2013	Master Chef Los Angeles, CA
	2012-Present	Regional Medical Center San Jose, CA **ASSISTANT ORTHOPAEDIC SURGERY PRIVILEGES**
	04/2013-PRESENT	MSLA, A Medical Corporation Various Locations in CA **DISABILITY EVALUATIONS VARIOUS AGENCIES**
	08/2015-PRESENT	Mesa Medical Group Garden Grove, CA **PRIMARY TREATING PHYSICIAN**
Licenses:	**1985 - Present** **1992 - Present**	**California - Unrestricted** **New York - Unrestricted**
Accomplishments:	2012-2013	Culinary Master Chef Program Los Angeles, CA

Frank Guellich, M.D.
Diplomate, American Board of Orthopaedic Surgery

3675 Ruffin Road, Suite 120
San Diego, CA 92123

Date: XX/XX/XXXX

Sample Report #1

Client
[redacted]

CLAIMANT: **XXXX**
ABC Client ID: XXXXX
EMPLOYER: XXXX[redacted]
OCCUPATION: [redacted]

INDEPENDENT MEDICAL EXAMINATION

As requested by ABC Client, the following is the summary of an Independent Medical Examination as requested by your agency.

IDENTIFYING DATA

The claimant's identity was verified through his photo ID.

SOURCE OF INFORMATION

The source of information was claimant, who was deemed an adequate historian. He drove himself to the examination. Medical records were also submitted and reviewed.

WORK HISTORY

The claimant worked for the XXXX [redacted] Worker. He started to work there in XXXX. He cannot remember the month. He last worked on [redacted] XXXX.

ALLEGATIONS

The claimant alleges lower back pain due to a work-related injury on [redacted] XXXX.

HISTORY OF PRESENT INJURY

The claimant injured his lumbosacral spine at work on [redacted], XXXX while trying to load the trash onto a dumpster.

The claimant was seen [redacted] on [redacted] XXXX for low back pain. The claimant was seen at [redacted] on [redacted] XXXX for low back pain and the claimant was treated with injection to the lumbosacral spine. He was given modified duty with no lifting over 10 pounds. The claimant was seen in [redacted] on [redacted] XXXX for low back pain and was treated with an injection. He had an MRI of the lumbosacral spine without contrast. The claimant was seen in [redacted] on [redacted] XXXX for low back pain. The claimant had modified work with restrictions. The claimant was seen in [redacted] on [redacted] XXXX for low back pain and had chiropractic care for his low back. The claimant was seen in [redacted] on [redacted] XXXX for low back pain and was treated with an injection.

The claimant was seen for a Qualified Medical Evaluation by Dr. [redacted] on [redacted] XXXX. He was diagnosed with degenerative disc disease of L3-L4 and L5-S1 but does not mention if he had an MRI. He mentions that a MRI done on [redacted] XXXX showed minimal disc herniation and desiccation of L3-4 and facet arthropathy at L5-S1 with no spinal stenosis.

The claimant was seen at [redacted] on [redacted] XXXX for low back pain. The claimant was given restrictions of no lifting more than 75 pounds. The claimant was seen at [redacted] on [redacted] XXXX for low back pain. The claimant was given restrictions of no lifting and carrying more than 20 pounds.

The claimant was seen at [redacted] on [redacted] XXXX. The plan was no work. The claimant was seen at [redacted] on [redacted] XXXX for low back pain. The plan was no work. The claimant was seen in [redacted] on [redacted] XXXX for low back pain. The plan was not available. The claimant was seen at [redacted] on [redacted] XXXX for low back pain. He had an MRI done on [redacted] XXXX at [redacted] and on [redacted] XXXX. The claimant was seen at [redacted] on [redacted] XXXX for low back pain. There was no plan. The claimant was seen at [redacted] on [redacted] XXXX for low back pain. The plan was P&S. The claimant was seen at [redacted] on [redacted] XXXX for low back pain. The plan was none. The claimant was seen in [redacted] on [redacted] XXXX for low back pain. There was no plan.

The claimant was seen in [redacted] on [redacted] XXXX for low back pain. The plan was continuation of medication. There was no mention about modified work. The claimant was seen in [redacted] on [redacted] XXXX for low back pain. The plan was an epidural injection as recommended. The claimant was seen at [redacted] on [redacted] XXXX for low back pain. The plan was not mentioned.

The claimant was seen at [redacted] on [redacted], XXXX for low back pain. The plan was repeat epidural injection on the lumbosacral spine. The claimant was seen at [redacted] on [redacted], XXXX for low back pain. The plan was to repeat epidural injection on the lumbosacral spine. The claimant was seen in [redacted] on [redacted], XXXX for low back pain. No plan was made. The claimant was seen at [redacted] on [redacted] XXXX for low back pain. There was no plan. The claimant was seen at [redacted] on [redacted] XXXX for low back pain. The plan was as previously, P&S.

CURRENT COMPLAINTS

The claimant complains of pain on his low back that radiates on left side and he fell on the right side. The pain is increased by lifting over 15 pounds and decreased by standing at least 20 to 30 minutes. It is increased mostly by walking more than three blocks. It is somewhat decreased by rest and by taking ibuprofen. It is somewhat decreased by chiropractic treatment.

PRIOR INJURIES

The claimant had a lumbosacral spine injury on the job in XXXX.

PAST MEDICAL HISTORY

The claimant's past medical history is significant for hypertension.

PAST SURGICAL HSTORY

The claimant had a hernia surgery in XXXX and carpal tunnel surgery on the right in XXXX related to work.

SOCIAL HISTORY

The claimant smokes but denies drinking alcohol.

FAMILY HISTORY

Noncontributory.

MEDICATIONS

The claimant is currently taking Prozac, aspirin 81 mg, gabapentin, ibuprofen, lisinopril, metformin, lorazepam, and naproxen 500 mg.

REVIEW OF MEDICAL RECORDS

- There was an MRI of the lumbosacral spine dated [redacted] XXXX which showed facet hypertrophy at L5-S1 and there is no spinal stenosis.

- There are multiple documents that are handwritten notes, duplicates, prescription pad notes, instructions to the claimant from [redacted], letters from [redacted] to the claimant, and other documents that are non-orthopedic in nature and are not summarized within this document.

- **Job duty statement** received for the occupation of [redacted] for the XXXX Unified School District. The claimant was required to occasionally sit stand walk reach above shoulder and below shoulder level, fine manipulate, power grasp, simple grasp and use the hands for repetitive keyboard and mouse use. Claimant was also required to lift 11 to 25 pounds occasionally. Frequently the claimant was required to bend at the neck and waist, twist at the neck and waist. The claimant was never required to run crawl kneel, climb, squat push or pull.

  The claimant typical duties would include sweeping, dusting, cleaning, scrubbing, stripping, shielding and waxing polishes, mopping floors in classrooms and similar facilities. He would be required to do the waxing and scrubbing of all facilities as well as operating equipment such as for polishing and scrubbing machines. He would also operate lawnmowers, edgers, weed eaters and power sweepers. He would do duties such as gathering and disposing of rubbish, paper leaves, as well as emptying and washing refuse containers. He would perform a variety of unscheduled custodial duties as requested by the school office and teachers. The job description also notes that part of the duties or special requirements are that he should be able to safely lift and carry items weighing up to 100 pounds. He would also need to safely move heavy supplies, machinery and equipment. Special requirements are also noted as needing stamina to stand and walk for long periods of time.

- The claimant's **retirement application** which was signed on [redacted] XXXX shows that he injured himself on [redacted] XXXX. He reports pulling a bag of trash and did not expect to be as heavy as it was. He felt something pull on his back. He reports that the limitations are of lifting nothing over 15 pounds, inability to stand, walk or sit for long periods of time.

- [redacted] XXXX this is a [redacted] The claimant was evaluated for back pain. Physical examination showed tenderness and spasm with normal range of motion. Gait was non-antalgic and symmetric. The claimant had full range of motion and neurologically he was intact. Mild spasms were noted. There was tenderness to palpation at the left lower lumbar area. Diagnosis strain of the lumbar region.

- [redacted] XXXX this is a [redacted] report. The claimant presented with a complaint of an injury to his lower back while he was pulling a bag of trash. The claimant

reported moderate dull achy pain in the left paralumbar area. Radiation to the back of the buttock and the mid-thigh in the posterior area was noted. Pain was increased with lifting heavy objects and decreased with rest. No numbness weakness or paresthesias were reported no bowel or bladder dysfunction was noted. No saddle anesthesia was noted. Physical examination findings included tenderness and spasm with normal range of motion. Gait pattern was non-antalgic and symmetric. He had tenderness to palpation at the left paralumbar areas. Range of motion was normal. Neurologically he was intact. He was placed off work until [redacted] XXXX with lifting of no greater than 10 pounds. The diagnosis was strain of the lumbar region.

- [redacted] XXXX this is a [redacted] report. The patient came in requesting a trigger point injection. Physical therapy has been attended but he still complains of moderate achy pain. Diagnosis was that of a strain of the lumbar region. A trigger point injection was administered without complications. Modified duty was recommended of lifting no more than 10 pounds.

- [redacted] XXXX this is a [redacted] report. Physical examination findings revealed tenderness and spasm. There was pain at the L5 -S1 and left paralumbar area. There's a positive straight leg raising test on the left. Diagnosis included strain of the lumbar region, lumbar radiculopathy -left, and herniation of the lumbar into vertebral disc, possible at L5 -S1. The claimant was placed on modified duty to lift and carry no more than 10 pounds for the next 2 to 3 months. Given the findings of a positive straight leg raising the physician stated he would order an MRI.

- [redacted] XXXX this is a [redacted] report. The claimant's physical examination showed tenderness. Normal range of motion. There was pain at the paralumbar area bilaterally at the L5-S1 region. Gait was non-antalgic. Straight leg raising was negative. Diagnosis was strain of the lumbar region.

- [redacted] XXXX this is a [redacted] report. The claimant was seen for a flare-up. He was given a trigger point injection. Without complications.

- [redacted] XXXX this is a [redacted] report. The claimant stated he felt much better with chiropractic. This pain has decreased to a 2/10 level. Physical examination noted pain in the left paralumbar area. Otherwise he did exhibit tenderness of the lower back. The rest of his physical examination is normal. Diagnosis was strain of the lumbar region. He was given modified work.

- [redacted] XXXX this is a [redacted] report. The claimant was noted to have worsening pain from last visit. Physical examination shows tenderness and spasm but normal range of motion. Diagnosis was strain of the lumbar region and bilateral carpal tunnel syndrome, not work related. Physical examination shows gait is non-antalgic. There is pain at the left paralumbar area. No midline pain. No radiation of the pain. Diagnosis is strain of the lumbar region.

- [redacted], XXXX this is a [redacted] report. The claimant reported numbness in the hands for the last three weeks without pain, paresthesias or weakness. He continued to complain of lower back pain. Physical examination notes a negative Spurling's test. There was tenderness and spasm in the lower back. However normal range of motion. The claimant had positive carpal compression test and phalen's test bilaterally. Diagnoses include strain of the lumbar region and bilateral carpal tunnel syndrome, not work-related.

- [redacted], XXXX this is a [redacted] report. MRI from [redacted] XXXX was reviewed from [redacted] Minimal disc herniation and desiccation at L3 -L4. Facet arthropathy at L5 -S1. No spinal stenosis. The claimant was noted to be improving.

- [redacted], XXXX this is a [redacted] report. Pain block consultation was denied. Moderate dull achy pain of the left paralumbar area and L4 -L5 midline with no radiation. Physical examination notes tenderness in the low back. Normal range of motion. Otherwise, no tenderness, swelling, edema, deformity, pain or spasm. Neurologically he is overall intact. Gait was normal. Diagnosis was that of a strain of the lumbar region. Chiropractic was recommended.

- [redacted] XXXX this is a [redacted] report physical examination showed pain in the left paralumbar area. No radiation. No pain at the midline. Diagnosis strain of lumbar region.

- [redacted] XXXX this is a [redacted] report. The lower back pain is noted to have improved from the previous evaluation. He still had occasional mild dull pain in the left paralumbar area. No radiation of pain. Physical examination showed tenderness of the lower back. Normal range of motion. There was pain at the paralumbar area. No radiation. Diagnosis was strain of the lumbar region. He was returned to full duty.

- [redacted], XXXX this is a [redacted] report. The claimant is noted to have been full duty prior to this evaluation. Chiropractic treatment was not helping. The claimant wanted a trigger point injection. Diagnosis was noted as a strain of the lumbar region. Trigger point injection was administered without complications.

- [redacted], XXXX this is a [redacted] report. Physical examination showed pain in the left paralumbar area with no radiation or midline pain. Diagnosis/strain of the lumbar region.

- [redacted], XXXX this is a [redacted] report. Physical examination shows tenderness of the lower back. Normal range of motion. Pain in the left paralumbar area. No radiation. No midline pain. Diagnosis strain of the lumbar region.

- [redacted], XXXX Dr. [redacted] M.D. this was a Qualified Medical Evaluation. The diagnosis was lumbar strain and degenerative disc disease of the lumbar spine the L3-L4 and L5-S1 levels.

- [redacted], XXXX this is a [redacted] report. Physical examination shows pain in the left paralumbar areas with no radiation. No midline pain. Diagnosis was strain of the lumbar region.

- [redacted] XXXX this is a [redacted] report noting lower back exhibiting tenderness. Normal range of motion. No bony deformities or swelling. There is pain in the left paralumbar areas with no radiation. Diagnoses. Lumbar region strain.

- [redacted] XXXX this is a [redacted] report. Physical examination findings showed normal gait range of motion of the spine was completely normal. There was tenderness to palpation at the left paralumbar area. No radiation was noted. Lifting trials were performed and the claimant was able to lift the hundred 20 pounds on trial one, hundred 10 pounds on trial two, and 100 pounds on trial number three. Diagnostic results were strain of the lumbar region.

- [redacted], XXXX this is a [redacted] report. The claimant was examined and gait was normal. Straight leg raising was negative. Sensation, strength and deep tendon reflexes were also normal. Lifting trials were notable for 120 pounds on trial one, 110 pounds and trial two, and 100 pounds. Diagnosis was strain of the lumbar region. Restrictions were given of no lifting more than 75 pounds.

- [redacted], XXXX this is a [redacted] report. The claimant was seen in physical examination. Findings revealed pain in the left paralumbar area and L5 -S1 midline. Straight leg raising was negative. Diagnosis of a lumbar region strain was given.

- [redacted], XXXX this is a [redacted] report. The claimant was seen for a flare-up of lower back pain. Physical examination showed tenderness and spasm. Normal range of motion with no bony tenderness, swelling or edema. Normal sensation strength and reflexes were seen. Gait was normal. Straight leg raising test was also negative. Diagnoses strain of the lumbar region and arthropathy of lumbar facet.

- [redacted], XXXX this is a [redacted] The patient reports feeling somewhat better from the last visit. Diagnosis strain of the lumbar region. He was given restrictions of standing as no more than 30 cumulative minutes per hour, no more than six hours per day. Walking has the same restrictions. Bending at the waist was to be done no more than 10 cumulative minutes per hour for no more than two hours per day. Climbing stairs and ladders was prohibited. Lifting and carrying was to be done no more than 20 pounds for no longer than 20 minutes per hour. Pushing and pulling was not to be more than 25 pounds for no longer than 20 minutes per hour. This report was signed by [redacted] MD.

- [redacted], XXXX this is a [redacted] report. A diagnosis of strain of the lumbar region is given. Examination exhibited tenderness. He also had decreased range of motion tenderness and pain. However, the ranges of motion are not documented.

- [redacted], XXXX this is a [redacted] report. Physical examination showed a positive straight leg raise. Laterality is not indicated nor at what degree. Diagnoses arthropathy of lumbar facet and lumbar radiculopathy.

- [redacted], XXXX This is a [redacted] report. Interlaminar lumbar epidural steroid injection procedure note. This is a report of a L5 -S1 trans-laminar steroid injection under fluoroscopy. No complications were noted. Physical examination noted tenderness and pain in the lumbar spine. He has normal range of motion. He had an abnormal straight leg raise test which was noted as slightly positive on the left. Gait was antalgic. The assessment was noted as arthropathy of lumbar facet, lumbosacral radiculitis, and disorder of lumbar intervertebral disc.

- [redacted] XXXX [redacted] report. On physical exam the claimant is noted to have tenderness to palpation at the right and left paralumbar areas. No tenderness over the midline sacrum or sacroiliac joints. Diagnoses are arthropathy of lumbar facet and lumbar radiculopathy.

- [redacted] XXXX [redacted] report. The claimant was noted to have tenderness to palpation at the right and left paralumbar areas. There were some mild spasms. But no tenderness over the midline, sacrum or sacroiliac joints. Diagnoses include arthropathy of lumbar facet, strain of lumbar region and lumbar radiculopathy.

- [redacted] XXXX the claimant suffered a flare-up according to the assessment. He had tenderness to palpation at the right and left paralumbar areas. There were mild muscle spasms. However, there is no tenderness over the midline sacrum or sacroiliac joints.

- [redacted] XXXX [redacted] report. The claimant is noted to be awaiting epidural #3. It is noted that injection #2 took place on [redacted]6, XXXX. This helped with decreasing pain and increasing function more than 90%. The claimant was diagnosed with lumbar radiculopathy, arthropathy of lumbar facet and strain of the lumbar region. (Whether this is #2 or #3 is in question in light of the [redacted] XXXX report where it states the physician is trying to obtain approval for injection #2).

- [redacted] XXXX [redacted] report. Physical examination shows tenderness to palpation at the right and left paralumbar areas. Some mild spasms were noted. Diagnoses are arthropathy of lumbar facet and lumbar radiculopathy.

- [redacted] XXXX [redacted] eport. This is a PR-2 report. Pain has gotten worse. The claimant has moderate dull achy pain in the left paralumbar area. There is a positive straight leg raising on exam, although the level is unknown. Diagnosis lumbar radiculopathy, arthropathy of lumbar facet and strain of the lumbar region.

- [redacted] XXXX [redacted] report. Positive straight leg raising was noted on this date. Neurologically he had no weakness and normal reflexes. No sensory deficits. Ranges of motion are not provided. Diagnoses arthropathy of lumbar facet, strain of lumbar region and lumbar radiculopathy. This report was used as an appeal for epidural

steroid injection number two. It was noted that the first injection on [redacted] XXXX helped with decreasing pain and increasing function more than 90%. Therefore, the argument is made that he should have one more steroid injection.

- [redacted], XXXX [redacted] report. This is a PR-2 report noting findings of an MRI of the lumbar spine done at [redacted] on [redacted], XXXX. The findings were that of minimal disc herniation and desiccation at L3-4. Facet arthropathy at L5-S1. No spinal stenosis. Physical examination shows tenderness and spasm in the lumbar spine. No weakness. Normal reflexes. No sensory deficit. Normal muscle tone. Normal straight leg raise test. Normal gait pattern. Diagnosis was that of lumbar radiculopathy, arthropathy of lumbar facet and strain of the lumbar region. The claimant was noted to be stable.

- [redacted] XXXX [redacted] History obtained reveals injury from [redacted] XXXX to the back. On [redacted] XXXX, he was evaluated by a Qualified Medical Evaluator. He was diagnosed with lumbar strain and degenerative disc disease at L3-L4 and L5-S1. Physical examination revealed moderate tenderness at L4-L5. Flexion was 60° and extension 20°. Straight leg raising was 90° on the right and 60° on the left. Positive sciatic notch on the left. Provocative tests are negative. Motor strength is 5/5. Sensation is noted as perhaps slight diminution left at L4 distribution. Deep tendon reflexes were normal. No atrophy is noted with both calves measuring 45 cm. diagnoses are lumbar radiculopathy, arthropathy of lumbar facet, strain of the lumbar region, chronic nonmalignant pain and severe obesity. The physical examination did not reveal evidence of radiculopathy. However the physician states that although there is lack of motor weakness, the patient does have radicular signs and is considered a red flag. He cites the ACOEM guidelines. He therefore requests an MRI.

- [redacted] XXXX (Date of receipt) [redacted] Physicians Supplementary Certificate signed by [redacted] MD. the diagnosis is noted as thoracolumbosacral neuritis and radiculitis. The physician noted that the patient had permanent work restrictions of no lifting over 15 pounds. No return to work date was offered.

- [redacted] XXXX [redacted] report. The allegations remain the same. Findings on physical examination include moderate tenderness at L4-L5 level. Flexion was to 60° and extension to 0°. Straight leg raising to 90° on the right and 60° on the left. Positive sciatic notch on the left. Provocative tests are negative. Neurologically he is intact except for diminution laterally at L4 to sensation. Diagnoses: severe obesity, lumbar radiculopathy, arthropathy of lumbar facet, and chronic nonmalignant pain.

- [redacted] XXXX [redacted] report. Physical examination findings of tenderness and spasm in the lower back. Normal range of motion. Normal sensation, strength and reflexes. No weakness. Diagnoses lumbar radiculopathy, arthropathy of lumbar facet and strain of the lumbar region.

- [redacted] XXXX [redacted] report. Patient is presenting with a diagnosis of lumbar strain and degenerative disc disease at L3–L4 and L5–S1. Physical examination

revealed moderate tenderness at the L4-5 level. There's decreased sensation at L4. Flexion is to 60°, extension 20°. Straight leg raising is 90° on the right and 60 on the left. Positive sciatic notch on the left. Diagnoses include chronic nonmalignant pain, severe obesity, strain of the lumbar region, and deconditioning.

- [redacted] report. MRI completed on [redacted]XXXX was reviewed and noted to be completely normal. some early degenerative joint disease at the level of L3 – L4 is noted, which is age-appropriate. Diagnoses include chronic nonmalignant pain, severe obesity, strain of the lumbar region, and deconditioning. Strengthening exercises were given and recommended.

- [redacted], XXXX [redacted] report. Follow-up report regarding moderately severe pain in the lower back with numbness in the toes of both feet. Examination findings revealed moderate tenderness at the L4-L5 level. Flexion is 60°, extension 0°. Straight leg raising is 90° on the right and 60 on the left. There's positive sciatic notch on the left. Provocative tests were negative. Sensation was decreased bilaterally at the L4 level. Sensation and deep tendon reflexes were normal. Diagnoses include chronic nonmalignant pain, strain of the lumbar region, severe obesity, deconditioning. All these were unchanged from previous visits.

- [redacted] XXXX [redacted] record. The claimant came in with moderately severe pain of the lower back with numbness in the toes of both feet. The numbness becomes more severe with prolonged sitting of over two hours. He had complaints of bilateral hand numbness as well. Physical examination showed pain to palpation and mild palpable tightness in the lumbosacral area. Flexion was to 30°, extension 20°. The claimant complained of pain with all motion. No weakness noted. Neurologically the claimant was intact. Diagnoses include lumbar ridiculous apathy, arthropathy of the lumbar facet and strain of the lumbar region.

- [redacted] XX [redacted] record. The claimant was seen for continued lower back pain. Permanent restrictions from heavy lifting were noted. Physical examination revealed moderate tenderness at the L4 and L5 levels. Flexion was 60°, extension 0° , straight leg raising 90° on the right and 60° on the left. Positive sciatic notch on the left. Neurologically sensation is decreased at L4.

- [redacted] XXXX [redacted] report notes the patient was there for moderately severe pain of the lower back with numbness in the toes on both feet. Physical examination showed moderate tenderness at the L4 L5 level. Flexion was 60°, extension 0°, straight leg raising 90° bilaterally. Provocative tests were negative. Neurologically there was sensory decrease bilaterally at the L4 distribution. Motor strength and reflexes were normal. MRI [redacted] XXXX was completely normal with mild early degenerative joint disease of the L3-L4 level which was deemed age-appropriate. Diagnoses were strain of the lumbar region, lumbar radiculopathy, chronic nonmalignant pain, deconditioning and severe obesity.

- [redacted], XXXX [redacted]e record noting lower back pain diagnosed as lumbar strain and degenerative disc disease L3-L4 and L5-S1. This was according to the history. Review of the MRI dated [redacted], XXXX was completely normal. Mild early degenerative joint disease was seen at L3-L4. However, this is noted as age appropriate. Diagnoses includes arthropathy of lumbar facet, strain of the lumbar region, lumbar radiculopathy, deconditioning and severe obesity.

- [redacted] XXXX Initial consultation. Dr. [redacted], physical medicine and rehabilitation provider evaluated this claimant for lower back complaints. Examination of the lower back shows 40° of flexion, 10° of extension, and 25° of lateral flexion, right and left. He moves slowly with complaints of generalized lower back pain. There is palpable trigger point with spasm overlying the left greater than right lower musculature. There is discomfort towards buttocks, on the left and right, when palpating the areas. There is tenderness overlying the left sciatic notch and left piriformis musculature. An MRI was reportedly done in XXXX but results were not available. Diagnosis is lumbosacral strain, recent exacerbation of prior permanent and stationary state.

- [redacted] XXXX initial consultation. The claimant is seen regarding his lower back injury of [redacted], XXXX. It is noted in this document that he denied history of previous injuries to his lower back. Physical examination showed 40° of flexion, 10° of extension and 25° of bilateral lateral flexion. The diagnosis was that of lumbosacral strain, recent exacerbation of prior permanent and stationary state.

- [redacted], XXXX Physician progress report. A reevaluation for persistent lower back discomfort associated with a XXXX industrial injury is noted. Physical examination of the lower back shows forward flexion to 45° and extension to 15°. Tenderness with spasm and palpable trigger points overlying the left greater than right lower lumbar muscles. Slightly positive straight leg raising maneuver left greater than right is noted. He continues to flex and extend his lower back in a slow manner. Diagnosis lumbosacral strain, recent exacerbation of prior permanent and stationary state.

- [redacted] XXXX Physicians progress report. Physical examination of the lower back shows flexion 45° extension 20°. There are trigger points overlying the left greater than right lower lumbosacral muscles. Palpation radiates discomfort towards both buttocks and posterior thigh. A slightly positive straight leg raising maneuver is noted, left greater than right. Diagnosis is lumbosacral strain, recent exacerbation of prior permanent and stationary state.

- [redacted] XXXX Physician progress report. Physical examination shows decreased range of motion in forward flexion to 45° and extension to 20°. Palpable trigger points with spasm overlying the left greater than right lower lumbar musculature. Diagnosis of lumbosacral strain, recent exacerbation of prior permanent and stationary state.

- [redacted] XXXX Physician progress report notes lower back discomfort associated with his [redacted] XXXX injury. Physical examination of the lower back shows flexion 45° and extension of 20°. Palpable trigger points overlying the bilateral lower back muscle

groups are noted. Palpation over the left lower lumbar area continues to radiate discomfort towards the left buttock. The posterior thigh as well. Minimally positive left-sided straight leg raising maneuver is noted. There is slight tenderness overlying the piriformis musculature and sciatic notch. The left greater than right. A diagnosis of lumbosacral strain is made. It is noted as recent exacerbation of prior permanent and stationary state.

- [redacted], XXXX primary treating physician's progress report knows tenderness with findings of tenderness. The diagnosis is noted as lumbosacral strain. The provider's handwritten recommendations are not legible.

- [redacted] XXXX Physician's progress report. Physical examination showed flexion of the lower back to 45° and extension of 20°. Palpable trigger points overlying the left greater than right lower lumbar muscles. Continued radiation of discomfort from the lower back towards the left buttock and posterior thigh. Continued slightly positive left-sided straight leg raising maneuver. Diagnosis lumbosacral strain, recent exacerbation of prior permanent and stationary state.

- [redacted], XXXX Initial consultation. The claimant was referred by treating physician [redacted] MD. Allegation was left greater than right lumbar radiculopathy. Physical examination revealed left greater than right lumbar paraspinal myofascial pain. He is noted to have L5 sensation deficits bilaterally. Ranges of motion are not recorded. Diagnostic testing is noted as a lumbar MRI that appears to be nonsurgical. Diagnosis was discogenic and radicular pain.

- [redacted], XXXX the claimant was evaluated for carpal tunnel syndrome with bilateral evidence of carpal tunnel syndrome based on EMG. Right-sided was moderate to severe. Left side was moderate. The claimant appears to have had a right carpal tunnel release on [redacted] XXXX. There is also a note of cervical radiculopathy. EMG done in [redacted] XXXX showed chronic left seventh cervical nerve roots abnormality. Bilateral fifth and sixth cervical nerve root abnormality. A recommendation for epidural was made at the C6-C7. Cervicalgia is also noted. The claimant has hypertension. The claimant is also noted to have an impaired fasting glucose. Intervertebral disc degeneration is noted. MRI of [redacted] XXXX is cited to show C-5 C6 degenerative disc disease with mild to moderate foraminal stenosis bilaterally. An injection was given in [redacted]XXX with some benefit. Lumbago is also noted with the claimant revealing two injuries. The first was in XXXX when he fell working as a [redacted]on a wet floor and reporting hitting his head and being evaluated but without any imaging. In XXXX, he was lifting a heavy bag and hurt his back and had a [redacted]case with [redacted]r. He had an MRI and was diagnosed with neuritis. In [redacted]XXX MRI showed mild lumbar spondylosis of L3 through L5. No spinal stenosis or neural foraminal impingement is noted. Major depression is also cited. Lastly obesity is noted. This examination took place at [redacted] The claimant was evaluated by [redacted] MD. a physical examination is not recorded.

- [redacted], XXXX physician progress report. Physical examination reveals bilateral lumbar paraspinal myofascial pain. S1 sensation loss with straight leg raise positive bilaterally. L5 sensation loss is also noted. In terms of diagnostic testing, it is stated that the MRI appears nonsurgical. The claimant brought in the images and these are reviewed by the physician who opines that he appears to have spinal stenosis at L4 L5 due to epidural lipomatosis. He states this is a quite obvious finding. Diagnosis is discogenic and radicular pain/spinal stenosis.

- [redacted], XXXX - Operative report for bilateral L5 transforaminal epidural steroid injection by [redacted] No complications were noted.

- [redacted] XXXX Physician progress report. Physical examination findings show bilateral lumbar paraspinal tenderness and L5 sensation deficits. Ranges of motion are not commented on. Impression: discogenic and radicular pain.

- [redacted] XXXX the initial pain management evaluation took place. The mechanism of the injury is reported as having fallen on his back and hitting his head in XXXX while pulling heavy bags. The claimant received physical therapy, acupuncture, x-ray, MRI and CT scan. However, the results are not noted. On physical examination, his gait was not antalgic. He was able to do heel to toe and toe to heel walk. Lumbar spine examination showed tenderness to palpation over the lumbar spine muscles. Diffuse reduction to sensation in the lower extremities to light touch are noted. However, no specific distribution is noted. Approximately 4/5 left and 5/5 right dorsiflexion are noted. There is an absent left patellar tendon reflex. Range of motion is reduced in all planes although no ranges are provided. Assessment is noted as lumbar radiculopathy and obesity. Recommendation for epidural steroid injection is made.

- [redacted] XXXX This is an incomplete report starting at page 2 noting diagnostic testing of nonsurgical MRI. However, no results are dictated into this report. The impression is discogenic and radicular pain. This report was signed by Dr. [redacted]

- [redacted], XXXX physician progress report knows that the claimant has not improved significantly physical examination shows tenderness over the lower back muscles, diffuse reductions in sensation in the lower extremities to light touch, 4/5 left and 5/5 right dorsiflexion, and an absent reflex of the left patella. Diagnoses are lumbar radiculopathy and obesity. The provider uses this report to appeal a utilization review denial.

- [redacted] XXXX PR-2 report notes a finding of positive straight leg raising although laterality is not known. A diagnosis of lumbar radiculopathy is made. Recommendation of bilateral L5 steroid injection is made. This report is signed by Dr. [redacted]

- [redacted] XXXX physician's progress report the claimant reports sciatica. This is worsened with walking and standing and is made better with sitting and resting. Physical examination reveals tenderness to palpation over the lower back muscles, diffuse reduction to sensation in the lower extremities to light touch, approximately 4/5 left and

5/5 right dorsiflexion, absent left patellar tendon reflex and decreased range of motion. Diagnoses include lumbar radiculopathy, obesity and diabetes. The physician is recommending repeat steroid injection.

- [redacted] XXXX Physician progress report noting improvement but slower than expected. Physical examination showed tenderness to palpation over the lower back muscles. Diffuse reduction in sensation in the lower extremities to light touch. Approximately 4/5 left and 5/5 right dorsiflexion. Left deep tendon reflexes are absent at the patellar tendon. Decreased range of motion of the lumbar spine is noted although no ranges are provided. Diagnoses are that of lumbar radiculopathy, obesity and diabetes. The plan was to have an L5 transforaminal epidural steroid injection scheduled for [redacted] XXXX. Refills of medications were provided. On the same day, the claimant completed an updated history form noting that he has neck pain and that both legs felt numb. He also complained of numbness in the hands.

- [redacted] XXXX physician progress report noting a worsening of symptoms with the pain score of 8/10. Physical examination showed tenderness to palpation over the lower back muscles. Diffuse reduction in sensation in the lower extremities to light touch. 4/5 left and 5/5 right dorsiflexion. Absent left patellar tendon reflex. Range of motion is decreased. However, range of motion is not noted. Diagnoses include lumbar radiculopathy obesity and diabetes. The claimant agreed to move forward with repeat epidural of the bilateral L5 level.

- [redacted] XXXX work status report noting a diagnosis of lumbago and neuralgia/neuritis NOS.

- [redacted], XXXX [redacted] MD - Transforaminal epidural steroid injection bilaterally at L5. No complications are noted.

- [redacted] XXXX Physician's progress report notes continued improvement but slower than expected of the sciatica. Physical examination has similar findings to all the other reports from [redacted]. Diagnosis includes lumbar radiculopathy, obesity and diabetes. The plan was to request an epidural injection.

- [redacted] XXXX a physician progress report notes continued complaints of sciatica with physical examination findings of tenderness to palpation in the lower back muscles, reduction in sensation in the lower extremities to light touch, 4/5 Left dorsiflexion strength, and an absent left patellar reflex. Range of motion was also reduced in all planes. Diagnoses are lumbar radiculopathy, obesity and diabetes.

- [redacted] XXXX [redacted], MD - Transforaminal epidural steroid injection bilateral at L5. This was done for radiculopathy. The indication notes that there has been failure to conservative therapy. Physical examination is overall normal, although no back exam is documented. No complications were noted.

- [redacted], XXXX This is a [redacted] Client form. [redacted] Request notes a claim for lower back accepted on [redacted] XXXX. Settlement for [redacted] award is noted. Dr. [redacted] is noted as the examining physician. This document was signed by [redacted] on [redacted], XXXX.

- [redacted] XXXX physician's progress report noting that the patient had improved. However, the claimant still had sciatica at a 7/10 level of severity. Physical examination showed tenderness to palpation over the lumbosacral muscles. There was diffuse sensation decrease in lower extremities to light touch. Left tendon reflex in the patellar tendon is absent and 1+ on the right. Range of motion is reduced in all planes due to pain. Diagnosis lumbar radiculopathy, obesity and diabetes.

- [redacted] XXXX PR-2 report noting decreased pain in the bilateral lower extremities. There was decreased range of motion on exam. However, the ranges of motion are not documented. Diagnosis is lumbosacral radiculopathy.

- [redacted] XXXX Physician report on disability notes a diagnosis of lumbar radiculopathy with increased pain when standing. Restrictions of no lifting over 15 pounds is noted. Incapacity is reported as permanent. This report is signed by Dr. [redacted] He is a pain medicine doctor.

- [redacted], XXXX Physical Capacities Evaluation form completed noting the claimant can only sit, stand and walk for three hours at one time and for three hours total in an eight-hour day. He was noted as never able to lift 11 to 20 pounds. Occasional bending and crawling. Never squatting and climbing. The form also gives restrictions of never working at unprotected heights, being around moving machinery, or driving automotive equipment. There are mild restrictions noted for exposing himself to changes in temperature and humidity and in exposure to dust, fumes and gases.

- [redacted] XXXX physician's progress report by [redacted] MD. The claimant notes sciatica is made worse with walking or standing. It is improved with sitting and resting. The pain is sharp and burning. Pins and needles, numbness and tingling are reported. Pain level is noted as 8/10. Lower back examination noted tenderness to palpation over the lower back muscles. There's diffuse reduction in sensation in the lower extremities to light touch. 4/5 Left and 5/5 rights dorsiflexion is noted. Left deep tendon reflex of the patella is absent. On the right, it is 1+. Decreased range of motion in all planes due to pain. Diagnoses include lumbar radiculopathy, obesity and diabetes.

- [redacted] XXXX primary treating physician progress report by Dr. [redacted] notes subjective complaints of decreased pain in the right and left lower extremities. Objective findings include increased range of motion. Diagnosis includes lumbosacral radiculopathy. The actual ranges of motion are not documented.

- [redacted], XXXX physician progress report by [redacted] MD the claimant is noted to have tenderness to palpation over the lumbar spine. There is decreased sensation in the lower extremities to light touch. 4/5 left end 5/5 right dorsiflexion. Left deep tendon

reflexes of the patellar tendon is absent. 1+ on the right. Range of motion reduced in all planes. Diagnoses include lumbar radiculopathy, obesity and diabetes.

- [redacted], XXXX examination by Dr[redacted]notes sciatica as the subjective complaint, decreased range of motion as the objective finding and a diagnosis of lumbosacral radiculopathy. Medications were recommended. No discharge status.

- [redacted], XXXX PR-2 report by Dr.[redacted]notes the claimant's work status continues the prior permanent and stationary status. Follow-up is recommended. Lumbar support brace is also ordered.

- [redacted] XXXX The claimant completed a patient updated history form noting that there is constant pain. He rates his pain at nine. He states that everything hurts when asked what activities or position made the pain worse. He did not note anything alleviating the pain.

- [redacted], XXXX[redacted] MD this is a physician's progress report noting that the patient had improved but slower than expected. Physical examination noted antalgic gait pattern. He had tenderness to palpation over the lumbar facets in the paraspinal musculature. Approximately 4/5 left and 5/5 right dorsiflexion. Range of motion was reduced in all planes of the lumbar spine due to pain. Diagnosis is noted as lumbar radiculopathy, obesity and diabetes.

- [redacted] XXXX patient was seen by Dr.[redacted] for sciatica. Decreased range of motion was found on exam. Lumbosacral radiculopathy was diagnosed with a tens unit being requested.

- [redacted], XXXX work status report by Dr. [redacted] notes improved but slower than expected. A physical exam is not summarized.

- [redacted], XXXX[redacted] MD this is a report of a transforaminal epidural steroid injection bilateral at L5.

- [redacted] XXXX[redacted] MD this is a history and physical. The claimant was seen for lower back complaints. No respiratory, gastrointestinal or cardiovascular issues are noted. Physical examination appears to be normal. However, no back examination is documented.

- [redacted] XXXX Work status report from [redacted]Medical Group. This report shows the patient was discharged as permanent and stationary. The name of the treating provider is known as [redacted] MD.

End of record review.

PHYSICAL EXAMINATION

GENERAL

Claimant is a male, who was cooperative with the exam. He was able to follow commands.

LUMBOSACRAL SPINE EXAMINATION

He can flex to 50 degrees, extend to 10 degrees, bend to 20 degrees, and rotate to 20 degrees with pain. He has tenderness on the left side.

Motor power in the lower extremities is 5/5.
Sensation to touch is 1+ in the lower extremities.
Reflexes in the lower extremities, knees, and ankles are 1+.
Bilateral straight-leg raising is negative, sitting and supine.

GAIT

Gait is normal.

LOWER EXTREMITY RANGES OF MOTION - BILATERAL:

Hips:

Abduction:	40 degrees
Adduction:	20 degrees
Flexion:	90 degrees
Extension:	30 degrees
External rotation:	40 degrees
Internal rotation:	40 degrees

Knee:

Flexion:	130 degrees
Extension:	0 degrees

Ankle

Dorsiflexion:	20 degrees
Plantar Flexion:	40 degrees

Foot

Inversion:	30 degrees
Eversion:	30 degrees

Leg Lengths

There is no leg-length discrepancy.

DIAGNOSTIC TESTS

None obtained.

DIAGNOSES

1. Lumbosacral spine mild ligamentous strain.
2. Lumbosacral spine facet hypertrophy in L5 and S1.
3. Diabetes Mellitus.
4. Overweight.
5. Hypertension.

DISCUSSION

The claimant injured his lumbosacral spine on [redacted]XXXX at work while lifting [redacted] He had an MRI report of the lumbosacral spine. He had treatment but with minimal benefits. There were no surgeries done. He had six epidural injections, chiropractic treatment, and acupuncture with some benefits. He also had physical therapy with minimal benefits. He had no nerve conduction or EMG studies of his extremities. He has not returned to work and has remained symptomatic in his low back.

Today's physical examination reveals that the lumbosacral spine is abnormal. The normal flexion is 60 degrees, he has 50 degrees. The normal extension is 30 degrees, he has 10 degrees. Lateral bending is normal at 30 degrees, he has 20 degrees. Rotation is normal at 30 degrees, he has 20 degrees. All motions are with pain.

An MRI report of the lumbosacral spine done at [redacted] on [redacted]XXXX showed L3-L4 minimal disc desiccation and herniation and L5-S1 facet hypertrophy with no spinal stenosis.

JOB DESCRIPTION

The claimant worked as a [redacted] for the XXXX [redacted] He sweeps, dusts, cleans, scrubs, sweeps, waxes, and mops all the classrooms, kitchen, dining hall, and restrooms.

He was responsible for the walls, woodwork, furniture and fixtures, shelves and boards.

He operates equipment such as floor polishers, a scrubbing machine, a washing machine, steaming and shampoo, vacuum cleaners, lawn mowers and lawn edgers. He sweeps the halls and tennis courts, school yard, playground and parkway. He moves and adjust chairs, desks, tables and other furniture.

He changes water from the compressor tank. He checks and maintains oil levels of the air compressors. He gathers and disposes rubbish bins. He empties and washes the containers.

ANSWERS TO SPECIFIC QUESTIONS

Your cover letter requested that specific questions be answered as part of this report. Below are the questions, followed by the answers.

1. Based on your objective findings, are there specific job duties that you feel the member is unable to perform because of a physical or mental condition? If so, please explain in detail for each disabling condition.

   Based on physical examination and MRI, the claimant is unable to do the job as required. He is unable to operate equipment such as floor polishers and scrubbing machines, steaming and shampoo machines and vacuum cleaners. He is unable to sweep and clean halls, tennis courts, school yards, playground and parkways. He is unable to move and adjust chairs, desks, tables and other furniture to prepare the room for a meeting. He is unable to check and maintain the oil level of the air compressor. He is unable to gather and dispose the rubbish properly. He is unable to operate power and pressure heating. He is unable to safely lift and carry items weighing more that 100 lbs. He is unable to move heavy machineries and equipment.

   The claimant is unable to do occasional sitting because of low back pain. He is unable to do occasional standing. He is unable to do twisting in his waist. He is unable to carry up to 100 pounds.

2. In your professional opinion, is the member presently, substantially incapacitated for the performance of his duties?

   Yes.

   a. If yes, on what date did the disability begin?

      The claimant's disability started on [redacted], XXXX.

   b. If incapacitated, is the incapacity permanent or temporary?

      The incapacity is permanent. Mr. Claimant cannot reverse or change the physical examination of the lumbar spine.

3. Is the member cooperating with the examination and putting forth their best effort, or do you feel there is exaggeration of complaints?

   I felt the claimant cooperated and put his best effort during the examination. I did not feel he was exaggerating his complaints.

This concludes my evaluation of this claimant. If you have any further questions, please do not hesitate to contact me.

Sincerely,

[redacted], ***M.D.***
American Board of Orthopaedic Surgery
[redacted]

Frank Guellich, M.D.
Diplomate, American Board of Orthopaedic Surgery
1816 Tully Road, Suite 235
San Jose, CA 95122

Sample Report #2

Date: [redacted]

XXXXXX
[redacted]

CLAIMANT: **XXXXX, XXXX**
XXXXXX ID: 0000000000
EMPLOYER: [redacted]
XXXXXX
OCCUPATION: XXXX [redacted]

INDEPENDENT MEDICAL EXAMINATION

As requested by XXXXXX, the following is the summary of an Independent Medical Examination as requested by your agency.

IDENTIFYING DATA

The claimant's identity was verified through her photo ID.

SOURCE OF INFORMATION

The source of information was claimant, who was deemed an adequate historian. Medical records were also submitted and reviewed.

WORK HISTORY

The claimant worked as a [redacted]. She started to work on [redacted] The last day she worked was in [redacted]

ALLEGATIONS

The claimant has a right wrist problem.

HISTORY OF PRESENT INJURY

The claimant had a gradual onset of right wrist pain with numbness to the right hand and wrist approximately in 2013. She had no specific injury to the right hand or wrist. She worked many years working with computers and files in computers. She was seen at [redacted] in 2013 in [redacted] for right wrist and right hand pain and numbness. She was given a prescription of anti-inflammatory medication of naproxen as well as started on occupational therapy in approximately [redacted] She does not remember the exact date. She was next seen by a private doctor, Dr. [redacted] an orthopaedic hand surgeon in [redacted]. Dr. [redacted] performed a surgery for the right wrist approximately in [redacted] She next had 12-14 weeks of physical or occupational therapy (she is not sure) on the right wrist and on the right hand with minimal benefit. She was then seen by Dr. [redacted] in [redacted]

Dr. [redacted] ordered a wrist MR with no contrast. She next had a ganglion removed on the right wrist. She had nerve release at the mid forearm at the dorsum but does not know exactly what that was. She then saw a physical therapist in [redacted] twice a week for eight weeks. She still sees Dr. [redacted] at the present for possible carpal tunnel syndrome.

She also has been seeing Dr. [redacted] since [redacted] She is supposed to have an EMG and a nerve conduction but it has not been approved by [redacted]

CURRENT COMPLAINTS

The claimant has constant pain in the right wrist. She has numbness and tingling in all four fingers and of the thumb. She takes Advil, ibuprofen with some benefit for the pain and numbness. She has difficulty even washing her hand or drying her hair. Currently, she had her hair short.

PRIOR INJURIES

None known.

PAST MEDICAL HISTORY

The claimant was treated for thyroid nodules. She has hypothyroidism. She has also been treated for anxiety and depression.

PAST SURGICAL HSTORY

The claimant had thyroid nodules biopsy surgery in [redacted] but no tumor. She had a deviated septum operated in [redacted]

SOCIAL HISTORY

The claimant denies smoking or alcohol intake.

FAMILY HISTORY

The claimant is single and has [redacted] children, ages [redacted]

MEDICATIONS

The claimant is currently taking venlafaxine, levothyroxine, losartan, and amlodipine.

REVIEW OF MEDICAL RECORDS

An MRI was reviewed. The summary of the large volume of medical records is summarized at the end of this report.

PHYSICAL EXAMINATION

GENERAL

The claimant is a female, who was cooperative with the exam. She was able to follow commands. The physical examination was done with a chaperone present.

UPPER EXTREMITIES - MEASUREMENTS

Measured 7 cm above the olecranon:
Right: 32 cm.
Left: 32 cm.

Measured 12 cm below the olecranon:
Right: 24 cm.
Left: 24.5 cm.

CERVICAL SPINE EXAMINATION

She can flex to 40 degrees, extend to 50 degrees, bend to 40 degrees, and rotate to 40 degrees.

Motor power in the upper extremities is 5/5.
Sensation to touch is 1+ upper extremities.

GAIT

Gait is normal.

UPPER EXTREMITIES - RANGE OF MOTION

Bilateral shoulders:

Abduction:	140 degrees
Adduction:	30 degrees
Flexion:	140 degrees
Extension:	30 degrees
External rotation:	30 degrees
Internal rotation:	30 degrees

Bilateral elbows:

Flexion:	140 degrees
Extension:	0 degrees

Bilateral forearms:

Pronation:	30 degrees
Supination:	30 degrees

Right wrist:

Flexion:	30 degrees
Extension:	60 degrees
Radial deviation:	20 degrees
Ulnar deviation:	30 degrees

Left wrist:

Flexion:	60 degrees
Extension:	60 degrees
Radial deviation:	20 degrees
Ulnar deviation:	30 degrees

Right wrist:

Flexion:	30 degrees
Extension:	40 degrees
Radial deviation:	20 degrees
Ulnar deviation:	20 degrees

Right hand:

The claimant is able to make a full fist.
Tinel's sign is positive.

Phalen's test is cannot be fully appreciated because she has limited flexion of the right wrist.
Thumb opposition is good.
Finger motion is good.
Atrophy: None.

Left hand:

The claimant is able to make a full fist.
Tinel's sign is negative.
Phalen's test is negative.
Thumb opposition is good.
Finger motion is good.
Atrophy: None.

DIAGNOSES

1. Right wrist pain status post ganglion and cyst removal at the dorsum of the right wrist.
2. Post De Quervain's release of the right wrist.
3. Most probable carpal tunnel syndrome on the right.
4. Overuse syndrome of the right wrist and right hand.
5. Right hand tendinitis.
6. Anxiety and depression, by history. This is deferred to the appropriate specialist for confirmation and opinion.

DISCUSSION

The claimant has had a gradual onset of pain and numbness in her right hand and right wrist since [redacted] She had no specific injury to the right hand and wrist. She presented with MRI of the right wrist with no contrast. She had right wrist surgeries including De Quervain's release, fourth compartment ganglion and cyst removal. She remains symptomatic in the right hand and wrist with numbness and tingling in all four fingers and the thumb. She has an EMG and nerve conduction of the right upper extremity pending but not approved at the present time.

Objective Findings:

The claimant was affected most probably with carpal tunnel syndrome, overuse syndrome, right hand and tendinitis of the right hand. Normal flexion is 60 degrees but she has 30 degrees. She also has a positive Tinel's sign in the right wrist.

Job Description/Job Analysis:

Type of Retirement: Industrial Disability Retirement
Occupation: XXXX [redacted]

Employer: [redacted]

Physical Requirements of Position/Occupational Title: The claimant is never required to run, crawl, kneel, climb, squat, bend at the waist, push or pull, lift/carry 11-100+ pounds, work with heavy equipment, be exposed to excessive noise, be exposed to extreme temperatures, humidity or wetness, work at heights, operation of foot controls or repetitive movement, use special visual or auditory protective equipment, or work with biohazards. The claimant is occasionally (up to 3 hours) required to stand, reach above and below shoulder, power grasp, simple grasp, lift/carry 0-10 pounds, drive, and be exposed to dust, gas, fumes and chemicals. The claimant is frequently (3-6 hours) required to sit, walk, bend neck and waist, perform fine manipulation, perform repetitive use of the hands, keyboard use, mouse use, and walk on uneven ground.

DIAGNOSTIC TESTS

The claimant had EMG and nerve conduction in [redacted] which was supposed to be normal.

ANSWERS TO SPECIFIC QUESTIONS

Your cover letter requested that specific questions be answered as part of this report. Below are the questions, followed by the answers.

1. Based on your objective findings, are there specific job duties that you feel the member is unable to perform because of a physical or mental condition? If so, please explain in detail for each disabling condition.

   Yes, she is not able to do the repetitive use of her hand required by her job. She is unable to do keyboarding and unable to use a mouse on the computer.

2. In your professional opinion, is the member presently substantially incapacitated for the performance of his/her duties? Please explain in detail.

   Yes, the member is substantially incapacitated. As explained above, she will not be able to perform the repetitive duties required of her job as they pertain to the hands. She also is unable to perform keyboarding or use of the mouse required by her position.

   a. If yes, on what date did the Disability begin?

      The Disability began on the last day she worked in [redacted]

   b. If incapacitated, is the incapacity permanent or temporary?

This is permanent. She will not have reversal of the overuse syndrome. At current, she most probably has carpal tunnel syndrome and this will not reverse.

3. Is the member cooperating with the examination and putting forth their best effort, or do you feel there is exaggeration of complaints?

   She is cooperating with the examination. No exaggeration was noted and I felt she gave her best effort.

4. Is the condition caused, aggravated or accelerated by their employment? Would these complaints be present if the claimant had not been employed in this job?

   The condition was caused by the employment. In my professional orthopaedic opinion, they would not be present if she had not been employed in this job.

This concludes my evaluation of this claimant. If you have any further questions, please do not hesitate to contact me.

Sincerely,

[redacted] ***M.D.***
American Board of Orthopaedic Surgery
[redacted]

Medical Record Review

[redacted] [redacted] M.D. - Doctor's Frist Report of Occupational Injury or Illness – Date of injury is [redacted], while at work. Subjectively the claimant notes that repetitive use of the keyboard, major job activities while working on the computer, and keyboard issues.
Objectively the claimant is in some distress over her symptoms, hitchhiker signs, tender over the 1st dorsal compartment, and Finkelstein signs.
The diagnoses include (1) de Quervain's tenosynovitis and (2) sprain/strain of the elbow and shoulder.
The treatment rendered include a thumb Spica splint, ibuprofen, and request ergonomic evaluation of work stations. Work status is modified duty from [redacted] to [redacted]

[redacted] [redacted] M.D. – [redacted], Work Status Report – The claimant is placed off work from [redacted] through [redacted]

[redacted] [redacted] NP – [redacted], Industrial Work Status Report – The claimant is placed on modified activity from [redacted] to [redacted]

[redacted] [redacted], M.D. State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant is wearing a thumb Spica splint, using ibuprofen as needed, awaiting an ergonomic workstation evaluation, and working modified duty.
Objectively the claimant has right elbow tenderness to palpation over the lateral epicondyle and extensor surface of the forearm. She has tenderness to palpation along the radial side. Positive Finkelstein's test.
Diagnoses include (1) de Quervain's tenosynovitis and (2) sprain/strain elbow and shoulder.
The claimant's treatment plan includes continuing the thumb Spica, awaiting physical therapy approval, HEP, and ergonomic workstation evaluation.

[redacted] [redacted] PT – Plan of Care Note – The claimant's treatment goals include to be able to perform computer related tasks including using the keyboard and mouse and to be able to write for 10-minutes in the next six weeks. Treatment is to include manual therapy techniques, therapeutic exercise, functional activity training, and home program education.
The assessment is right tendonitis, de Quervain's and tendinitis of the right wrist.

[redacted] [redacted]g, return to work coordinator – Memorandum – The claimant is placed on limited duty effective [redacted] to [redacted] with an anticipated return to full duty on [redacted] Limited duty to include no forceful pushing, pulling or grasping with right shoulder be able to take a 15-minute break from repetitive activities.

[redacted], NP – [redacted], Industrial Work Status Report – The diagnosis is tendonitis, de Quervain's. The claimant is to return to full capacity on [redacted]

[redacted], M.D. – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant complains of persisting pain over the radial side of the right wrist. She is wearing a Spica splint.
Objectively the claimant has right elbow tenderness to palpation over the lateral epicondyle and extensor surface of the right forearm and wrist.
The diagnoses include (1) de Quervain's tenosynovitis and (2) sprain/strain of elbow and shoulder.
The treatment plan includes continue thumb Spica, continue physical therapy, await ergonomic evaluation, and return to full duty on [redacted]

[redacted], M.D. – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant reports increasing pain in the radial side of the right wrist, wearing a Spica splint, and using ibuprofen as needed.
Objectively the claimant has right upper extremity tenderness to palpation over the lateral epicondyle and extensor surface of the forearm. Tenderness to palpation along the radial side with STS.
The diagnoses include (1) de Quervain's tenosynovitis and (2) sprain/strain of elbow and shoulder.
The treatment plan includes referral to Dr. [redacted] for a cortisone injection. She is to continue the thumb Spica, continue physical therapy, and ergonomic evaluation. Work status is full duty with a return to clinic on [redacted]

[redacted], M.D. – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – Subjectively the claimant complains of increased pain and she feels she is unable to return to work. She has an ergonomic evaluation on [redacted] and is working full time.
Objectively the claimant has right upper extremity tenderness to palpation over lateral epicondyle and extensor surface of forearm. She has STS radial side along the APL.
The diagnoses include (1) de Quervain's tenosynovitis and (2) sprain/strain of elbow and shoulder.
Her treatment plan includes a referral to Dr. [redacted] for cortisone injection, continue thumb Spica, physical therapy per plan of care, and ergonomic workspace evaluation. The claimant is to be off work on [redacted] and return to full duty on [redacted]

[redacted], NP. – [redacted] Industrial Work Status Report –

Diagnosis includes tendonitis, de Quervain's. The claimant is placed off work on [redacted] to return to full duty on [redacted]

[redacted] M.D. – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – Subjectively the claimant complains of increasing pain. The claimant had an injection on [redacted] and is working full duty.
Objectively the claimant has right wrist tenderness to palpation and STS on the radial side along APL.
The diagnoses included (1) de Quervain's tenosynovitis and (2) sprain/strain of elbow and shoulder.
Her treatment plan is to continue thumb Spica, physical therapy per plan of care, Full duty on [redacted] with a return visit on [redacted]

[redacted], PT – PT Progress Note – Referring diagnoses include right tendonitis, de Quervain's and tendinitis of wrist. Treatment goals are that she will be able to perform computer related tasks including using the keyboard and mouse in six weeks. Treatment is to include manual therapy techniques, therapeutic exercise, functional activity training, and home program education.

[redacted], M.D. - [redacted], Consultative Evaluation and Opinion – The primary diagnosis is de Quervain's tenosynovitis with a secondary diagnosis of sprain/strain of elbow and shoulder. The claimant's job involves lots of keyboarding, etc. The claimant has pain in the radial aspect of her right wrist and some dysesthesias into the radial dorsal side of the hand. She has pain with resistance to thumb extension. The claimant has right radial wrist tendinitis and after discussion with the claimant she had a steroid injection.

[redacted], M.D. – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant reports having difficulty working regular duty due to pain on radial side of wrist. She is wearing splints. She is awaiting adjustments and equipment from an ergonomic evaluation.
Objectively the claimant has tenderness to palpation and mild STS.
The diagnoses included (1) de Quervain's tenosynovitis and (2) sprain/strain of the elbow and shoulder.
The treatment plan included cortisone injection, continue thumb Spica, follow up with Dr. [redacted] physical therapy, and modified work status from [redacted] to [redacted]

[redacted] M.D. State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant reports increased pain in the right radial wrist. Dr. [redacted] recommended surgery. She is having difficulty working modified duty with current restrictions. She is wearing a splint and is requesting medication refills.

Objectively the claimant has tenderness to palpation and mild STS on the radial side along APL and tenderness of the anterior shoulder. She has a positive Finkelstein's test.
Diagnoses include (1) DeQuervain's tenosynovitis and (2) sprain/strain of the elbow and shoulder.
The treatment plan is to continue the thumb Spica, request authorization of surgery for right radial wrist tenosynovectomy, request individualized physical therapy, counseling evaluation, and a HEP. She is to return to work on modified duty from [redacted] through [redacted] due to pain. Follow up on [redacted]

[redacted], M.D. – [redacted] Medical Group, Inc., Primary Treating Physician's Progress Report – Subjectively the claimant has right wrist burning sensation that awakens her at night with numbness, tingling, and pain. The examination reveals a positive Finkelstein's sign on the right.
The diagnosis is right de Quervain's disease, active.
Dr. [redacted] feels that the claimant needs a DeQuervain's release of the right wrist. The claimant is able to continue working with modifications and would like to proceed with the surgery. Follow-up in two weeks.

[redacted], M.D. – [redacted] Medical Group, Inc., Primary Treating Physician's Progress Report – Subjectively the claimant has right wrist burning sensation that awakens her at night with numbness, tingling, and pain. The examination reveals a very positive Finkelstein's test with a mobile cyst over the 1st dorsal compartment.
The diagnosis is right de Quervain's disease, active.
The plan is that the claimant needs a 1st compartment release of the right wrist and the claimant agrees.

[redacted], M.D. - [redacted] Surgery Center, Surgical Note – The preoperative and postoperative diagnosis was DeQuervain's tenosynovitis, right wrist. The operation performed was a release of first dorsal compartment, multiple compartments, right wrist.
It is noted that the claimant tolerated the procedure well and was taken to the recovery room in good condition.

[redacted] M.D. – [redacted] Medical Group, Inc., Primary Treating Physician's Progress Report – Subjectively the claimant has right wrist burning sensation that awakens her at night with numbness, tingling, and pain. The examination reveals that she is healing well.
The diagnosis is right de Quervain's disease, active.
The plan is to have sutures removed in three days, gentle therapy, and follow-up in three weeks.

[redacted] M.D. – [redacted] dical Group, Inc., Primary Treating Physician's Progress Report – Subjectively the claimant has right wrist burning sensation that awakens her at night with numbness, tingling, and pain. The examination reveals slight swelling.
The diagnosis is right de Quervain's disease, active.
The plan is to continue splinting and therapy with a follow-up in 4-6 weeks.

[redacted] Early Intervention Counseling Report – The claimant described the cumulative activities of her work that caused the injury to her right dominant wrist and shoulder.
Dr. [redacted] noted that further EIC services may be indicated.

[redacted] M.D. – [redacted] Medical Group, Inc., Primary Treating Physician's Progress Report – Subjectively the claimant has right wrist burning sensation that awakens her at night with numbness, tingling, and pain. The examination reveals pain poorly localized to the wrist with difficulty sleeping.
The diagnosis is right de Quervain's disease, active.
The plan is to increase activities, continue strengthening, and Ambien

[redacted] M.D. – [redacted] Medical Group, Inc., Primary Treating Physician's Progress Report – Subjectively the claimant has right wrist burning sensation that awakens her at night with numbness, tingling, and pain. The examination reveals weakness and stiffness. She has complaints of burning on exam.
The diagnosis is right de Quervain's disease, active.
The plan is to continue therapy 2x week for 4 weeks for strengthening.

[redacted] M.D. – [redacted] Medical Group, Inc., Primary Treating Physician's Progress Report – Subjectively the claimant has right wrist burning sensation that awakens her at night with numbness, tingling, and pain. The examination reveals burning and stiffness complaints.
The diagnosis is right de Quervain's disease, active.
The plan is to continue usual and customary work for four weeks and then re-evaluate.

[redacted] – [redacted], Inc., [redacted] Note – The claimant is seen for de Quervain's release evaluation. She reports that her keyboard was broken and the keys were very stiff, which in turn aggravated her symptoms. Her pain is rated 5/10 to 8/10 with use.
Objectively the claimant has right dorsal and radial wrist pain, tingling, numbness, and tightness in the right dorsal forearm and right palm. She had a positive radial tunnel compression intensities with tingling in the right palm and

tightness in the dorsal wrist. Treatment included gentle wrist PROM, STM/releases to right brachioradialis, thenar muscles, extensor and flexor muscles. She is looking for an old brace that she had. Plan is for NHP, CP, paraffin, ultrasound, progressive ROM/strengthening, nerve glides, soft tissue massage, and splinting as needed.

[redacted], OTR/L – [redacted] Inc., SOAP Note – The claimant reports feeling about the same as last week. Treatment included paraffin with MHP, STM/releases to right forearm, thenar muscles, FOS, POP, FCR, and FCU extensor wad. HEP and composite thumb flexion stretches. The claimant tolerated the treatment well and is to continue with heat, stretches, STM, and strengthening.

[redacted] M.D. – Doctor's First Report of Occupational Injury or Illness – The claimant's date of injury is listed as [redacted] and the injury is listed to be related to work. The examination involves her right hand and right wrist. pain is described as 5/10, constant, sharp and burning with tingling and numbness from the thenar area to the right thumb and external right forearm. She also has depression and anxiety with fatigue, crying, and anhedonia. She is being treated at [redacted] with medications for this, which has helped. She has sleep disturbance with 4 hours of sleep secondary to worries and pain in her right hand and wrist. The right hand and wrist have a healed scar to the radial aspect of the wrist, tenderness over the scar, and positive Finkelstein's tests.
The diagnoses include (1) de Quervain's tenosynovitis, (2) right thumb pain, (3) depression, (4) sleep disturbance, and (5) hypertension, nonindustrial.
The treatment plan includes HEP, TENS, paraffin bath, depression screening, sleep hygiene, request PT at GGHT, request psychologist and CBT x12, and request orthopedic records. The claimant is off work until her follow up in four weeks.

[redacted] OTR/L – [redacted] Inc., [redacted] Note – The claimant reports now starting to be seen by pain management. Her right hand continues to feel "heavy", tender in the right wrist, and claimant reported pain after strengthening HEP. Objectively the shoulder depression intensifies the heaviness feeling in the right hand with relief on scapular elevation. HEP, corner stretches, and shoulder shrugs are to continue.
The claimant tolerated the treatment well and would benefit from proximal strengthening to improve heavy sensation in the right hand. She would benefit from resting and strengthening with HEP. She is to continue proximal strengthening, STM, gentle resume strengthening in right hand/thumb as appropriate.

[redacted] PA - [redacted] Division of Workers' Compensation, Primary

Treating Physician's Progress Report – The claimant notes right hand and wrist pain that is constant at a level of 6/10 with radiation to the elbow. It is also associated with numbness, burning, and tingling sensations.
On examination, the right wrist surgical scar is well healed on the radial aspect of the wrist. There is decreased ROM to flexion. There is tenderness to palpation near the radial styloid and over the scar.
The diagnoses include (1) right thumb pain, (2) de Quervain's tenosynovitis, (3) sleep disturbance, and (4) depression.
She is to continue conservative care, schedule paraffin treatment, continue PT, request for psychologist and CBT x12 sessions, request psychiatrist evaluation for medication management, and obtain orthopedic records.

[redacted] OTR/L – [redacted] Inc., Chart Note – The claimant reports right wrist/thumb levels are about the same. Pain at its worst is 5/10 while writing or driving. She has positive Phalen's test and positive radial tunnel compression with right hand symptoms. Treatment included paraffin bath with MHP, STM/releases, foam roller, median nerve glides, PROM and composite thumb flexion. Claimant declined CP. She is to continue HEP. She tolerated the treatment well and is to continue strengthening as tolerated and PROM/stretches.

[redacted] M.D. - State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report - The claimant had an ergonomic evaluation on [redacted] including a wireless mouse, keyboard, and headset. The claimant has right thumb pain, depression and anxiety, and sleep disturbance. The claimant has a scar on the radial aspect of the wrist. There is tenderness over the scar area. There is a positive Finkelstein's test.
The diagnoses include (1) right de Quervain's tenosynovitis, (2) depression, (3) sleep disturbance, and (4) hypertension, nonindustrial.
It is noted that HEP is helping, she is to have a TENS trial on [redacted] continue PT, continue medications, depression screening on [redacted], sleep hygiene pending, psychologist evaluation and CBT pending, requested records from Orthopedic Surgeon, and claimant is off work.
Her work status is to remain off work for four weeks.

[redacted] – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report (poor copy) – Claimant presents to a TENS trial today. She has a right wrist surgical scar that is well healed on the radial aspect. Decreased ROM with flexion. Tenderness to palpation over radial styloid and over the scar.
Diagnoses include (1) right thumb pain, (2) de Quervain's tenosynovitis, (3) depression, and (4) sleep disturbance.
The treatment plan is to perform the TENS trial today, continue conservative

care, continue physical therapy, psychologist and CBT therapy sessions pending, request psychiatrist evaluation for medication management, obtain reports from orthopedics, and return in one month for follow-up.

[redacted], Inc., Chart Note – The claimant reports right wrist/thumb levels are about the same, but feels benefit from the foam roller. Treatment included paraffin bath with MHP, STM/releases, foam roller, median nerve glides, PROM and composite thumb flexion. Claimant declined ice. She is to continue HEP. She tolerated the treatment well and is to continue stretches, strengthening, and nerve glides.

[redacted], Inc., Chart Note – The claimant reports feeling about the same with tightness in the right forearm extending into the thumb. Treatment included ultrasound to the right forearm, STM/release to right brachioradialis, stretching, gentle wrist PROM, and joint mobility exercises.
The claimant has very tight myofascial tissue in the right forearm. She tolerated treatment well. She is to progress to the next treatment.

[redacted] Psy.D. – [redacted]edical Clinic, Inc., Confidential Psychological Evaluation – The claimant became mildly tearful when discussing changes to her life brought on by her injury. Her affect ranged from calm to sad/tearful. The claimant currently reports pain in the right wrist that is described as burning in nature, pain/numbness in the right thumb that radiates to the forearm and is described as constant and similar to the right wrist pain, sleep disturbance, changed appetite, and notable fatigue.
The DSM diagnosis included major depressive disorder, single, severe.
Treatment recommendations are that the claimant CBT and psychotropic medications as medically necessary to address her depression and referral to psychiatrist for ongoing psychotropic medication management.

[redacted], [redacted]– Chart Note – The claimant reports that she fell while trying to protect her right wrist and her right knee is swollen and a toenail is torn. She reports continued pain/difficulty with personal care and fine manipulation. The right wrist and thumb are stiff leading to pain. At worst the pain is 7/10 after typing/writing for two minutes.
On examination, the claimant has slight edema/stiffness as noted in the dorsal right wrist near the extensor retinaculum, positive Finkelstein's, and slight pain/popping with thumb circumduction.
Her treatment included MHP to the right wrist, STM/releases to right thenar muscles, biceps stretching. She is to continue HEP, PROM of thumb, and compression sleeve at night.

[redacted], [redacted] – State of California Division of Workers' Compensation,

Primary Treating Physician's Progress Report – The claimant presents for a depression screening. On examination, the claimant has decreased ROM with flexion, tenderness to palpation near the radial styloid and over the scar of the hand and thumb.
The diagnoses include (1) right thumb pain, (2) de Quervain's tenosynovitis, (3) depression, and (4) sleep disturbance.
The treatment plan is to continue conservative care, request venlafaxine, continue physical therapy, continue CBT with Dr. Underwood, obtain records from [redacted] for paraffin treatment, HEP, and sleep screening.

[redacted], M.D. – [redacted] Medical Clinic, Inc., Work Status Form – The claimant is to remain on temporary total disability from [redacted] to [redacted]

[redacted], Psy.D. – [redacted] Medical Clinic, Inc., Confidential Psychological Progress Note – The claimant reported that she had a meltdown, crying a lot when talking to a good friend about her situation. She indicates that it bothers her when emotions overwhelm her despite trying to be positive. Affect was euthymic. Psychology provided education on Gate Theory of Pain as rationale for working on emotions to assist with pain tolerance. Psychology provided education and guidance on diaphragmatic breathing to manage stress and reduce emotional reactivity.
The DSM diagnoses included major depressive disorder, single, severe.
The treatment recommendation was to continue CBT as recommended.

[redacted] M.D. – State of California Division of Workers' Compensation – Primary Treating Physician's Progress Report – The claimant had an ergonomic evaluation on [redacted] including a wireless mouse, keyboard, and headset. The claimant has right thumb pain, depression and anxiety and sleep disturbance. The claimant has a scar on the radial aspect of the wrist. There is tenderness over the scar area. There is a positive Finkelstein's test.
The diagnoses include (1) right de Quervain's tenosynovitis, (2) depression, (3) sleep disturbance, and (4) hypertension, nonindustrial.
Her work status is to remain off work for four weeks.

[redacted] - State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant presents for sleep evaluation. Epworth score is 4. She sleeps very light and walks up 3-4 times a night due to pain. She reports right hand and wrist pain, constant at 7/10 with radiation up to the elbow. She had improvement with wrist splint and naproxen. She is currently not working with positive depressive symptoms.
The diagnoses include (1) right thumb pain, (2) de Quervain's tenosynovitis, (3) depression, and (4) sleep disturbance.
The treatment plan is to continue conservative care, appointments for paraffin

treatment, depression screening, and physical therapy. Requesting a trial of gabapentin.

[redacted], M.D. [redacted] Medical Clinic, Inc., Initial Psychiatric Evaluation – The claimant notes that she is "open for options to assist with my depression". The claimant's history was reviewed. The claimant notes a depressed mood, low energy, loss of motivation and anhedonia, sleep disruption, trouble concentrating, trouble making decisions, increased appetite, and significant weight gain.
On mental status examination, the claimant has a moderately restricted affect and a depressed or sad mood.
The diagnosis is major depressive disorder, single episode, moderate.
Causation is the industrial injury of [redacted]. Her work status is deferred to her PTP. her treatment plan is to increase venlafaxine and return in three weeks.

[redacted] Psy.D. – [redacted] Medical Clinic, Inc., Confidential Psychological Progress Note – The claimant reported mild improvement in her mood with less crying/emotional reactivity. Triggers were discussed. Affect was euthymic. We worked on reframing thoughts about her future to help her focus on activities that she can control at this time.
Her DSM diagnosis is major depressive disorder, single, moderate.
Treatment recommendations include continued work with psychiatry for medical management.

[redacted] M.D., [redacted] – [redacted], Hand Specialist Consultation/Request for Steroid Injection/Request for Right Wrist MRI – the claimant developed right upper extremity symptoms from repetitive keyboarding at work. She has had considerable conservative care. She had surgery and had postoperative therapy. She tried modified duties after surgery, but just could not do it anymore.
Subjectively the claimant notes a pulling sensation at and proximal to the surgery site with some numbness on the dorsoradial aspect of her right hand. She awakens three times a night because of her extremity discomfort despite the naproxen.
Examination reveals the postsurgical scar on the right radial wrist that is slightly thickened and hypertrophic. With ulnar wrist deviation, there is minimal tethering of the right thumb into extension. There is a pulling sensation with the Finkelstein's test. Thumb discomfort with provocative testing of the extensor compartment tendons. The MP joint had the slightest ulnar sesamoid metacarpal irritation initially but on subsequent examination there was none. There was slight tenderness on thumb with hyperextension. She did report slightly reduced sensation on the dorsal radial aspect of her right hand compared to the left. Right wrist ROM is restricted.

Assessment and diagnoses include (1) status post right de Quervain's release on [redacted] with residual pulling and wrist stiffness, (2) right radial neuritis post de Quervain's release without signs of nerve injury, (3) right intersection syndrome, and (4) focal right dorsal wrist tenderness, rule out ganglion cyst.
The recommendations include steroid injections after the MRI and treat her sleep disturbance.
Work status is that modified duties within limits of discomfort may continue, however, she seems fairly limited. She should be permanent and stationary within three months from now.
Apportionment is related to the [redacted] industrial injury.
Medical treatment includes passive wrist stretching exercises and continue medications to prevent stiffness.

[redacted] Medical Clinic Inc., Confidential Psychological Progress Note – The claimant describes her mood as up and down since last session. She had she recently lost her [redacted] and recently has not worked on her homework or practiced adequate selfcare. Affect was somewhat sad and restricted but not overly emotional. We discussed coping strategies and I helped with processing grief, focusing on aspects of her medical care that are going well, and worked on re-establishing focus on what she can control.
DSM diagnosis is major depressive disorder, single, moderate.
The treatment plan was to continue CBT sessions and contact clinic for earlier appointment to refill medications.

[redacted] M.D. – [redacted]ary Treating Physician's Progress Report – The claimant has depression and anxiety that causes fatigue. She also notes right thumb and right wrist pain graded at 7/10. The pain is dull and sometimes tingling at the dorsal aspect of the wrist and going up the extensor aspect of the left forearm.
Objectively the claimant has pain with range of motion of the right hand and thumb, well healed scars with tenderness over the scar area, and tenderness to the dorsal aspect of the wrist. There is a positive Finkelstein's test.
The diagnoses are (1) right wrist sprain, rule out ganglion cyst, (2) ganglion cyst of the right wrist as per Dr. [redacted] pending MRI to confirm, (3) right de Quervain's tenosynovitis, (4) depression, (5) sleep disturbance, and (6) hypertension, nonindustrial.
Plan is for continued HEP, TENS unit trial, continue medications, continue psychiatric care, and request MRI. The claimant is to remain off work for four weeks.

[redacted] M.D. – Health Diagnostics, Imaging Report – The claimant had a STAMI exam to evaluate a ganglion. The impression was (1) dorsal intercarpal synovial/ganglion cyst measuring 1.8x0.6x0.8cm, (2) negative ulnar variance with

minimal distal radial edema and minimal scattered carpal bone cystic changes, and (3) minimal extensor carpi ulnaris tendinosis is seen.

[redacted] M.D. – [redacted] Medical Clinic, Inc., Work Status Form – The claimant is to remain on total temporary disability from [redacted] to [redacted]

[redacted], M.D., [redacted], Treating Physician's Supplemental Report – The claimant notes ongoing worsened right dorsal wrist and forearm discomfort. Examination confirms considerable point tenderness in the midpoint of the area of intersection. The dorsum of the wrist is boggy with slight piriform fullness.
Diagnoses include (1) status post right de Quervain's release on [redacted] with residual pulling and wrist stiffness, (2) right radial neuritis post de Quervain's release without signs of nerve injury, (3) right intersection syndrome, and (4) focal right dorsal wrist tenderness, rule out ganglion cyst.
It is recommended that approved steroid injections be given and return in two weeks to assess injection effectiveness. Modified duties have not been available involving only brief periods of writing and typing, therefore she has been off since [redacted]

[redacted], [redacted] Medical Clinic, Inc., Confidential Psychological Progress Note – The claimant reported that she is feeling physically much better after needing to cancel last session due to illness. Her mood is improving but she has difficulty managing stress and frustration at times. Sleep continues to impact her pain. Affect was euthymic. Sleep hygiene was discussed.
Her DSM diagnosis is major depressive disorder, single, moderate.
The claimant is to continue CBT as planned and she is to be referred to a psychiatrist for ongoing medication management.

[redacted], M.D. – [redacted] Medical Clinic, Inc., Work Status Form – The claimant is to remain on total temporary disability from [redacted] to [redacted]

[redacted], M.D., F.A.C.S. – [redacted], Treating Physician's Supplemental Report/Request for Surgery – Subjectively she is sleeping better between the injections and oral medications. She is still having some tethering and extremity discomfort that prevents her from working.
Objectively the examination reveals tenderness on the dorsum of the wrist and there is a very tender cystic mass. With provocative testing she still has pulling sensation at the first extensor compartment and there is tenderness at the area of intersection in the midportion.
Assessment includes (1) status post right de Quervain's release on [redacted] with residual pulling and wrist stiffness, (2) right radial neuritis post de Quervain's release without signs of nerve injury, (3) right intersection syndrome

still significantly symptomatic post injection on [redacted], and (4) symptomatic right dorsal wrist ganglion cyst, MRI proven.
Recommendations include surgery including right dorsal wrist ganglionectomy and treatment of intersection syndrome. Return for preoperative preparations once authorization has been obtained. Postoperative therapy will most likely be needed as well.

[redacted] – [redacted] Medical Clinic, Inc., Confidential Psychological Progress Note – The claimant reports that she had a slight setback when she told she would need another surgery. She had many negative thoughts related to the surery and long recovery as well as limits to functionality and need for help during the recovery. Affect was mildly sad. Work was done on cognitive restructuring by provision of education and the influence our thoughts have on our emotions and behavior.
DSM diagnosis is major depressive disorder, single, moderate.
Treatment is to include continued sessions of CBT as planned and continue to recommend that the claimant be referred to a psychiatrist for ongoing medication management.

[redacted] – [redacted] Medical Clinic, Inc., Work Status Form – The claimant is to be on total temporary disability from [redacted]

[redacted] – [redacted] Medical Clinic, Inc., Mental Health Progress Report – The claimant describes her mood as up and down. She worries about her upcoming surgery, which has put a mild strain on her relationships. She is taking antidepressants regularly. She feels she is managing her stress, mood symptoms, and pain better than before. On the Beck Depression Inventory the claimant scored a 35, which is suggestive of a severe level of depressive symptoms and this represents progress. On the BAI she received a score of 19, which is suggestive of low level anxiety that is similar to the level endorsed at initial evaluation.
Her DSM diagnosis is major depressive disorder, single, moderate.
The claimant's treatment plan was to continue with planned sessions and continue requesting psychiatric exam for ongoing medication management.

[redacted] – [redacted] Medical Clinic Inc., Confidential Psychological Progress Note – The claimant described her mood as anxious. Affect was euthymic. We worked on challenging negative thoughts related to the surgery and explored other techniques such as positive self-talk and reframing in preparation for surgery.
The diagnosis is major depressive disorder, single, moderate.
The treatment recommendations include continue sessions and refer to psychiatrist for ongoing medication management.

[redacted] [redacted] Medical Clinic Inc., Work Status Form – The claimant is on total temporary disability from [redacted] to [redacted]

[redacted] [redacted] M.D., F.A.C.S. – [redacted], Treating Physician's Supplemental Report – Subjectively the claimant notes ongoing tenderness in the dorsum of the wrist and distal forearm. She notes tightness and tenderness along the back of her thumb.
Objectively the examination reveals a hypertrophic longitudinal scar on the right radial wrist about a 1cm area just distal to this part of the same scar is barely discernable. She has a small but very tender cyst mass on the dorsum of the right wrist just ulnar to the midline. Swelling and considerable tenderness in the area of intersection less in the 2nd extensor compartment. There is minimal tethering of the right thumb into extension.
The diagnoses include (1) status post right de Quervain's release on [redacted] with residual pulling, wrist stiffness, and a hypertrophic scar with minimal tethering, (2) right radial neuritis post de Quervain's release without signs of reparable nerve injury, (3) right intersection syndrome persisting post injection on [redacted], and (4) symptomatic right dorsal wrist cyst, MRI proven.
The recommendations are that she knows pre-surgical instructions. The claimant will begin complete temporary disability on [redacted] before some modified duties are made possible.

[redacted] [redacted] – [redacted] Medical Clinic, Inc., Work Status Form – The claimant is to remain on total temporary disability from [redacted] to [redacted]

[redacted] [redacted] – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant continues to report right wrist pain, 40% improvement with splint and meds, and positive depressive symptoms.
The diagnoses include (1) right thumb pain, (2) de Quervain's tenosynovitis, and (3) depression.
The plan was to refill medications, continue conservative care, return to clinic for paraffin treatment, continue HEP, and continue to see psychologist [redacted]

[redacted] [redacted] – [redacted] Medical Clinic, Inc., Confidential Psychological Progress Note – The claimant reported that she did not have wrist surgery as planned secondary to being ill. she described her mood as anxious about the surgery. She is sleeping poorly.
DSM diagnosis was major depressive disorder, single, moderate.
Treatment recommendations include continue sessions as planned and continue to authorized CBT sessions. Continue requesting the claimant be referred to a psychiatrist for ongoing medication management after the departure from the

clinic of Dr. [redacted]. The expected outcomes is that the claimant will improve her functioning, prevent further decline, and relieve/improve distressing symptoms.

[redacted] M.D., [redacted] – [redacted] Treating Physician's Supplemental Report – The claimant's surgery was delayed because of flu, but now she has recovered.
Objectively the claimant has a minimally thickened scar longitudinally over the first extensor compartment. There is minimal tethering of the right thumb into extension with ulnar wrist deviation. There is tenderness at the second extensor compartment and especially in the area of intersection at distal forearm.
The diagnoses include (1) status post right de Quervain's release on [redacted] with residual pulling, wrist stiffness, and hypertrophic scar with minimal tethering, (2) right radial neuritis post de Quervain's release without signs of repairable nerve injury, (3) right intersection syndrome persisting post injection on [redacted], and (4) symptomatic right dorsal wrist cyst, MRI proven.
The recommendations include continuing with surgery. She will remain off work.

[redacted] – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant presents for follow up with continued reports of right upper extremity pain. She reports a good mood on exam and is eager to proceed with surgery.
The diagnoses included (1) de Quervain's tenosynovitis and (2) depression, major, not specified.
The treatment plan was to proceed with surgery, refilled medications, postop PT pending, continue with [redacted] continue HEP, and continue TENS unit. Return to clinic in four weeks.

[redacted] C – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant presented for follow-up and reports continued right upper extremity pain. She reports a good mood today and is eager to proceed with surgery.
The diagnoses include (1) de Quervain's tenosynovitis and (2) depression, major, not specified.
The plan is to refill medications, postop physical therapy is pending, continue follow-up with [redacted], continue HEP, and continue TENS unit. Remain off work for four weeks and return in four weeks.

[redacted] – [redacted] Medical Clinic, Inc., Work Status Form – The claimant is to remain on total temporary disability from [redacted] to [redacted]

[redacted] M.D. – [redacted] Surgery Center, Inc., Surgical Note – Preop and postop diagnoses included (1) right dorsal wrist ganglion, (2) right wrist mid-

carpal synovitis, (3) right second extensor tendonitis, and (4) right forearm intersection syndrome.
Procedure performed is listed as (1) excision of right dorsal wrist radiocarpal ganglion, (2) arthrotomy for synovectomy of mid-carpal joint, (3) release of right second extensor compartment, and (4) tenolysis of distal forearm for intersection syndrome, separate incision.

[redacted], M.D., F.A.C.S. – [redacted] Treating Physician's Supplemental Report – Subjectively the claimant had pretty intense discomfort for the first day and a half but she has been starting to do exercises since.
Objectively the examination reveals that the sutures have just been removed and she has considerable swelling about the fingers, hand, and wrist. She has 25 degrees of right wrist volar flexion and 35 degrees of dorsiflexion and the finger slowly touches the proximal palm and misses the distal palmar crease by about half a centimeter.
The diagnoses include (1) status post right de Quervain's release on [redacted] with some residual pulling, stiffness, hypertrophic scar, and minimal first extensor tethering, (2) right radial neuritis post de Quervain's release surgery, (3) right forearm intersection syndrome status post-surgery tenolysis on October 6, 2015, (4) status post release right second extensor tendinitis, and (5) status post excision of right dorsal wrist ganglion on [redacted]
It is recommended that she continue therapy and return in three weeks for re-evaluation of work status.

[redacted] – Intake Form – The claimant's job title is listed as [redacted] for the [redacted] lists her date of injury as [redacted] with the body parts affected as right fingers and right wrist.

[redacted]. – [redacted] Medical Clinic, Inc., Confidential Psychological Progress Note – The claimant reported that she has had emotional ups and downs since surgery. She is trying to use therapeutic techniques to manage pain. Discomfort is also impacting her sleep. Affect was primarily euthymic.
DSM diagnosis is listed as major depressive disorder, single, moderate.
The treatment recommendations are to continue her course of planned therapy and attend CBT with the hopes of improving her functioning, preventing further decline, and relieving/improving distressing symptoms.

[redacted] M.D. - [redacted] Treating Physician's Supplemental Report/Work Change – Subjectively she has been having some radiating pains along the extensor forearm and she notes the adherent scab on the dorsum of the right hand.
Objectively the examination reveals a 1.5mm x 3mm adhered exudate on the

dorsum of the right wrist ganglion incision. There is a firm, woody induration about the surgical sites. She demonstrates 20 degrees of passive right wrist volar flexion and 35 degrees of passive dorsiflexion. There is also pulling in the forearm of the Finkelstein's test, but not the radial wrist.
Diagnoses included (1) status post right de Quervain's release on [redacted] with some residual pulling, stiffness, hypertrophic scar, and minimal first extensor tethering, (2) right radial neuritis post de Quervain's release surgery, (3) right forearm intersection syndrome status post-surgery tenolysis on [redacted], (4) status post release right second extensor tendinitis status post release right second extensor compartment on [redacted] and (5) status post excision of the right dorsal wrist ganglion on [redacted]
The claimant is encouraged to advance beyond her restrictions as discomfort may allow. Medications were refilled. Modified duties at work are to be resumed [redacted] with a maximum of minutes per hour of writing, keying, or typing and one pound of lifting.

[redacted] Medical Clinic, Inc., Work Status Form – The claimant is to be on total temporary disability from [redacted] to [redacted]

[redacted] provider – [redacted], Response Letter – Subjectively the claimant has functional limitations such as opening a jar, turning the door knob, putting a key in to drive, driving, personal hygiene, folding clothes, and writing.
Objectively the claimant has restricted right wrist ROM, decreased wrist strength, and edema. Sensation reveals numbness in the thenar region and back of the hand. The wound is healing with a dry scam on the proximal scar of the forearm.

The assessment and plan are that the claimant is recommended to have skilled OT twice a week for right upper extremity function. This is to include gradual progressive stretching and manual therapy techniques.

[redacted]. – [redacted] Medical Clinic, Inc., Work Status Form – The claimant is to remain on total temporary disability from [redacted] to [redacted]

[redacted] own Physician – Internal Medicine and Pain Management – (page 158) Handwritten and very difficult to discern.

[redacted] Medical Clinic, Inc., Confidential Psychological Progress Note – The claimant describes her mood as up and down, but she feels it is generally improving and that she is managing the ups and downs. Affect was euthymic.
Her DSM diagnosis was major depressive disorder, single, mild.
Treatment recommendations include finish this course and continue to CBT

therapy course.

[redacted], [redacted] – [redacted] [redacted] Note – Subjectively the claimant states that she is getting more range of motion now, however, still has burning pain in the wrist.
Objectively the claimant received treatment to improve right upper extremity ROM, massage of the scar tissue, and reviewed HEP.
Assessment includes that the claimant is improving in therapy with increased wrist movement.
The plan is to continue POC for 45 minutes.

[redacted], [redacted]. – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – Subjectively the claimant has a pain level of 6-7/10, she reports increase in sharp shooting pain in the right wrist to the fingertips. She states that she cannot hold on to the steering wheel or type for more than a minute. She has positive weakness, numbness, and tingling.

Objectively she has tenderness to palpation near the radial styloid and thumb, decreased flexion, and positive Phalen's test.
The diagnoses include (1) de Quervain's tenosynovitis and (2) depression, major, not specified.
The treatment plan is to refill medications, start gabapentin, request surgery report from Dr. [redacted] continue physical therapy, continue psychology visits with Dr. [redacted] continue HEP, and continue TENS unit. The claimant is to remain off work for four weeks and return for evaluation at that time.

[redacted] – [redacted] Independent Medical Review Final Determination Letter – Final determination is to uphold, which means that none of the disputed items/services are medically necessary and appropriate.

[redacted] – [redacted] Medical Clinic, Inc., Work Status Form – The claimant is to remain off work from [redacted] to [redacted] on total temporary disability.

[redacted], [redacted] – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – Subjectively the claimant continues to have right wrist pain while objectively she has a well healed surgical incision on the dorsal right wrist.
The diagnoses included (1) de Quervain's tenosynovitis and (2) depression, major, not specified.
The treatment plan is to decrease venlafaxine, refill medications, follow up with Dr. [redacted] and encouraged to begin HEP. She is to remain off work until [redacted]

[redacted] D.O. – [redacted] Medical Clinic, Inc., Work Status Form – The claimant is on total temporary disability from [redacted] to [redacted]

[redacted], OTR, LCHT – [redacted] Inc., [redacted] Note – Subjectively the claimant's pain is slightly better but still really hurts when she tries to push up from a chair.
Objectively paraffin and MHP to the wrist and hand, massage and desensitization, and STM/MFR forearm.
Assessment includes forearm extensor tightness and tenderness with limited wrist flexion contributing to functional limitations like performing backside hygiene.
The plan is to continue as planned.

[redacted], [redacted] – [redacted] Medical Clinic, Inc., Confidential Psychological Progress Note – The claimant reports that her mood is improving. She continues to have ups and downs related to work and her limitations due to her injury. Affect was euthymic.
Her DSM diagnosis was major depressive disorder, single, partial remission.
The treatment recommendations included that she continue therapy and progress to CBT. She is to learn to assess symptoms and stability in the final session after her return to work in February.

[redacted] – [redacted] Secondary Treating Physician's Supplemental Report – Subjectively the claimant has two therapies left. the claimant was placed on a nerve medicine, but there is more burning sensation over the dorsal radial wrist.
Objectively the claimant has right wrist dorsiflexion of 42 degrees and volar flexion of 24 degrees. There is a minimally thickened but wide scar on the dorsum of her left wrist post ganglionectomy. She also mentions that the right thumb seems to start getting caught for the past two weeks and she notes the abnormal motion at the IP joint.
Diagnoses include (1) status post right de Quervain's release on [redacted] with some residual pulling, stiffness, hypertrophic scarring, and minimal first extensor tethering, (2) right radial neuritis post de Quervain's release surgery, (3) right forearm intersection syndrome status post-surgery tenolysis on [redacted], (4) status post release right second extensor tendinitis status post release right second extensor compartment [redacted], (5) status post excision of right dorsal wrist ganglion on [redacted], and (6) possible right trigger thumb versus early right thump IP arthritis.
Dr. [redacted] recommends that the claimant continue passive wrist stretches and finish therapy appointments. Return in three weeks for follow-up. The claimant is to continue off work.

[redacted], M.D. – [redacted] M.D., Inc., Panel Qualified Medical Evaluation – Medical records and medical history were reviewed. Her current complaints included pain in the right hand that hurts most over the extensor compartment of the right wrist in a partial wrist C-like distribution. She complains of deep, aching, throbbing, tingling, burning, radiating, and numb pain to the right thumb on the right side only. The left hand does not bother her. The pain makes it hard for her to write and type as well as sleep.

Her job description was reviewed.

On physical examination, her right wrist range of motion was limited and her right grip strength was decreased when compared to the left. She had changes of the upper extremities that looked like either stretch marks and on her right antecubital fossa it looked like she had had a lot of IVs started in the past with some scarring. She also said they were stretch marks on her right elbow. On the extensor component there were port stab versus an incision site which was hypertrophic measuring 2x0.5cm with hardness, induration, and palpable scar tissue. There were some superficial abrasions from sutures on the extensor compartment of the wrist with a lot of swelling over that area. The extensor compartment of the thumb area revealed hypertrophy and another scar measuring 1.5x0.5cm with palpable scar tissue. It was indurated and hard. The left elbow had an incision with mild hypertrophy at the ends of it measuring 5cm in its length and almost 1cm at its greatest width. There was diffuse swelling about the right extensor compartment of the wrist and of both hands. There was mild subluxation of the CMC joints. Finkelstein's test was positive on the right.

Diagnoses for the claimant included (1) [redacted] Dr. [redacted] release first dorsal compartment, multiple compartments, right wrist for right wrist de Quervain's, (2) [redacted], excision of right dorsal wrist radiocarpal ganglion with arthropathy for synovectomy, mid-carpal joint release of right second extensor compartment with tenolysis of the distal forearm, for intersection syndrome, separate incision, (3) right wrist arthritis, (4) excessive scar tissue from surgeries with hypertrophy from 1-2, (5) diminished right grip strength, (6) depression and anxiety, (7) insomnia, and (8) chronic pain.

The claimant is noted to be permanent and stationary as of evaluation date. Causation is noted to be from the injury of [redacted] while working in her usual and customary position. 100% of assigned impairment is industrial and related to her work for the [redacted] No outside nonindustrial apportionment is indicated. The impairment rating is complicated. [redacted]% right upper extremity impairment, [redacted]% related to right upper extremity scar tissue and lack of resolution of symptoms from two surgeries, [redacted]% add on for pain is indicated. Dr. [redacted] notes that in his expert medical analysis to obtain an accurate rating, the impairments in this case do not overlap and should be added rather than combined.

Future medical care is noted to be continued treatment with her PTP for visits, medication and injections. She has revision of her scar by plastic surgeon

included as future medical care. Further testing could also be performed.

[redacted], M.D. – [redacted] M.D., Inc., Nerve Conduction Study Report – History of right upper extremity/hand pain with numbness.
The summary is that all nerve conduction studies are normal. The needle EMG examination of all tested muscles is normal.

[redacted], D.O. – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – Subjectively the claimant had an AME with Dr. [redacted] on [redacted]. She has continued right hand pain and difficulty sleeping.
Objectively the claimant has well healed surgical incisions.
Her diagnoses included (1) de Quervain's tenosynovitis and (2) depression, minor, not specified.
The treatment plan including awaiting the QME report. continue medications, trial of Lunesta, encourage HEP, manage pain, and she is to remain off work until [redacted]

[redacted] – [redacted] Medical Clinic, Inc., Work Status Report – The claimant is totally temporarily disabled from [redacted]

[redacted] M.D., [redacted], Secondary Treating Physician's Supplemental Report/Request for Additional Postoperative Therapy – Subjectively the claimant had a QME with Dr. [redacted] on [redacted] who indicated to her that she would be returning to her preinjury work. She still has two original therapy sessions left. She tried using a computer for about an hour on Wednesday and that caused great increased discomfort and she has not gone back to it.
Objectively the examination reveals right wrist volar flexion of 30 degrees and 40 degrees of dorsiflexion. She initially grasped her fingers to do the stretches. Grip strength is 22/34 R/L.
Diagnoses include (1) status post right de Quervain's release on [redacted] with some residual pulling, stiffness, hypertrophic scar and minimal first extensor tethering, (2) right radial neuritis post de Quervain's release surgery, (3) right forearm intersection syndrome, status post-surgery tenolysis on [redacted] (4) status post release right second extensor tendinitis, status post release of right second extensor compartment on [redacted] (5) status post excision of right dorsal wrist ganglion on [redacted] and (6) possible right thumb versus early right thumb IP arthritis.
Recommendations include completing her current therapy. Requesting eight additional postoperative therapy visits. Work status includes modified duties, which cannot be accommodated, therefore she is to remain off.

[redacted] – [redacted] Medical Clinic Inc., Work Status Form – Total temporary disability from [redacted] to [redacted]

[redacted] – [redacted] Medical Clinic, Inc., State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant complains of constant right wrist pain that is described as aching pain with level of 4/10. Paraffin bath of the right wrist decreased pain less than 50%.

The diagnoses include (1) right thumb pain, (2) de Quervain's tenosynovitis, (3) depression, (4) hypertension, (5) hypothyroidism, and (6) sleep disturbance.

The treatment plan includes refilling medications, continue conservative care, return to clinic for paraffin treatment, completed PT with minimal benefit, continue HEP, and continue psychology treatment with Dr. [redacted]. The claimant is to remain off work until TTD.

[redacted], - [redacted] Medical Clinic, Inc., Mental Health Progress Report – The claimant has attended 12-sessions of psychotherapy incorporating cognitive behavioral mood and pain management techniques including cognitive restructuring, positive self-talk, guided imagery, mindfulness, pacing, activity scheduling, communication skill building, and diaphragmatic breathing. The claimant reported that psychology has helped a great deal. Currently, because she is trying to reassess what she will do in her life, she is feeling more helpless but she reports that she is generally coping better. Over the course of treatment, the claimant demonstrated congruency and consistency in the report of symptoms. She never appeared to be exaggerating her pain level or emotional ailments for secondary gain or empty to gain sympathy.

Testing revealed an initial BDI score of 51, suggestive of extreme level depressive symptoms, and most recently a BDI score of 33, suggestive of slightly lower but still severe level depressive symptoms. On the BAI she endorsed low level anxiety symptoms at initial evaluation and mild symptoms with situational stressors at midpoint of therapy and a slightly lower, but still mild level of anxiety symptoms as of her final session with a score of 17. The claimant remained stable with similar levels of clinically significant pain catastrophizing. Helplessness has increased to a 98th percentile, which is consistent with her report in session that she feels helpless and congruent with someone who has recently learned that their plans for return to work cannot be realized. Rumination is slightly lower at 91st percentile, but still clinically relevant.

Her DSM diagnosis is major depressive disorder single, mild to moderate. Estimated GAF score of 61 with a WPI of 14.

Causation, disability and apportionment include injuries to the psyche including the events of employment as the predominant cause (51% or more). The issue of causation seems relatively straightforward and unambiguous. The industrial psyche injury is a compensable consequence of this admitted physical injury. The

psychiatric disorders listed on Axis I appear to be virtually entirely industrial in nature. I found the claimant to be a credible historian and did not find any evidence of symptoms exaggeration of pain amplification. Causation appears to easily exceed the 51% threshold.

The claimant is stable at this time; however, she is experiencing increased symptoms at this time as noted. Given her injury, ongoing stressors exacerbate her condition. She may require up to 15 psychotherapy sessions per year to be used at her discretion when her mood symptoms exceed her ability to cope.

[redacted] – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant denies new symptoms. She continues to report wrist pain described as aching pain with level of 4/10.

The diagnoses include (1) right thumb pain, (2) de Quervain's tenosynovitis, (3) depression, and (4) sleep disturbances.

Her treatment plan includes refilling venlafaxine, continue conservative care, return for paraffin treatments as needed, completed PT, continue HEP and to see Dr. [redacted] and request authorization for psychiatrist evaluation for medication input. She is to remain on modified work from [redacted] to [redacted] as per QME dated [redacted]

[redacted]. – [redacted] Medical Clinic Inc., Work Status Form – Modified duties from [redacted] to [redacted] of climbing up to two hours only, reaching with the right hand for up to two hours only, bilateral hand grasping, pulling and pushing of no more than 15-pounds for up to two hours only. Claimant would benefit from dragon software.

[redacted] M.D. - [redacted] Supplemental Secondary Treating Physician's Report – Subjectively she was found permanent and stationary with disability and permanent restrictions in January 2016 in an AME with Dr. [redacted]. The assessment and diagnoses included (1) status post right de Quervain's release on [redacted] with some residual pulling, stiffness, hypertrophic scar, and minimal first extensor tethering, (2) right radial neuritis post de Quervain's release surgery, (3) right forearm intersection syndrome, status post-surgery and tenolysis on [redacted], (4) status post release right second extensor tendinitis status post release right second extensor compartment on [redacted] (5) status post excision of right dorsal wrist ganglion on [redacted] and (6) possible right trigger thumb versus early right thumb IP arthritis.

Recommendations are to practice passive stretching exercises, continue eight additional therapy sessions, and return for MMI/P&S evaluation. Her work status is with modified duties, however, these have not been accommodated.

[redacted] _ State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – The claimant denies new symptoms. She completed her CBT with Dr. [redacted] however, she feels stress and anxiety about going back to work and would like to see Dr. [redacted] a few more times. She still reports wrist pain that is described as aching at a level of 4/10.
The diagnoses included (1) right thumb pain, (2) de Quervain's tenosynovitis, (3) depression, and (4) sleep disturbance.
The treatment plan included venlafaxine, request CBT x3, request paraffin home unit, continue conservative care, complete PT, continue HEP, request for authorization for psychiatrist evaluation for medication management. The claimant is to remain off work until [redacted] and then return to modified work as per QME dated [redacted].

[redacted] – [redacted] Medical Clinic Inc., Work Status Form – Modified duties from [redacted] to [redacted] of climbing up to two hours only, reaching with the right hand for up to two hours only, bilateral hand grasping, pulling and pushing of no more than 15-pounds for up to two hours only. Claimant would benefit from new software.
(note the copy is cut off at this point)

[redacted] – [redacted] Medical Clinic, Inc., Mental Health Progress Report – Subjectively the claimant describes her mood as overwhelmed and depressed. She is doubting her ability to return to work after approximately two years absent.
Objectively, Mr. [redacted] has previously benefitted from physical therapy, regularly using therapeutic techniques. She presents today as overwhelmed and sad. Self-doubt it likely related to depression. Affect appears similar but slightly worse than when I saw her last February, however, she reached out at that time to seek help, which is a good sign. On the Beck Depression Inventory, she received a score of 39, which is suggestive of severe level depressive symptoms. On the BAI, she reviewed a score of 5, which is not suggestive of clinically significant levels of anxiety. This represents improvement as compared to mild anxiety at termination in February.
Medical records were reviewed.
The DSM diagnosis is major depressive disorder, single, moderate.
Impression is that the claimant presents with increased symptoms of depression as compared to when she completed a course of psychotherapy in [redacted] Today we discussed coping strategies for managing her stress related to issues, I provided educational materials on depression for her partner, and in my professional opinion the claimant is in need of continued psychotherapy to help manage her depressive symptoms as she transitions back to work with restrictions.

The claimant's treatment plan is to request an additional 10-12 psychotherapy sessions to help in her recovery from clinical depression.

[redacted], Notice of Utilization Review Determination to the Non-Physician Provider – A request for venlafaxine 75mg for "other chronic pain" is certified to start [redacted] and end [redacted]

[redacted] M.D. – [redacted], Notice of Utilization Review Decision – Items requested and approved include psychology visits for CBT x4, consultation with a psychiatrist for evaluation for medication input, venlafaxine 75mg, DME purchase-Paraffin home unit.

[redacted], M.D. – [redacted] Secondary Treating Physician's Supplemental Report – Subjectively the claimant has two therapies left, which have been helping a lot; especially the paraffin baths. She is still having some difficulty sleeping, especially when her wrist is in the dorsiflexed position. She would like to try regular work, but does not know her functional capacity.

Objectively the examination reveals right wrist volar flexion at 37 degrees and dorsiflexion to 40 degrees. She still notes some numbness in the radial nerve distribution. Grip strength is 40 pounds on the right compared to 34 pounds on the left.

Assessment includes (1) status post de Quervain's release on [redacted] with some radial pulling, stiffness, hypertrophic scar, and minimal first extensor tethering, (2) right radial neuritis post de Quervain's release surgery, (3) right forearm intersection syndrome, status post-surgery, tenolysis on [redacted] (4) status post release of right second extensor tendinitis status post release of right second extensor compartment on [redacted] (5) status post excision of right dorsal wrist ganglion on [redacted] and (6) probable early right thumb IP arthrosis, trigger thumb seems unlikely.

Recommendations are that she continue her passive stretches. I believe her motion and strength have stabilized, but her ability to work remains unknown. MMI and P&S is off until it is clear whether she can return to work or not full unrestricted.

The claimant is able to return to work and attempt to sustain her regular duties, but this is up to her PCP, [redacted] direction. I am also requesting that the claimant get an at home paraffin bath unit so she can do it every morning and as needed.

[redacted] D.O. – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – Diagnoses include (1) de Quervain's tenosynovitis and (2) depression, major, not specified.

This reports notes that it was "dictated" and therefore all that was included was

the diagnoses.

[redacted] – [redacted] Medical Clinic, Inc., Work Status Form – Modified duties [redacted] to [redacted] No lifting greater than 15-pounds and limited to 2 hours on keyboard.

[redacted] – [redacted] Medical Clinic, Inc., Primary Physician's Progress Report – In response to a request made for clarification of work restrictions assigned [redacted] My physician's assistant made a request for accommodations with touch screen computer and Dragon software, however, the claimant's employer is unable to accommodate these requests.
The claimant's medical history was reviewed.
Subjectively the claimant notes right upper extremity pain and complains of residual right wrist stiffness. Her pain level is 2/10 in intensity at the time of the examination today. Pain is described as dull and localized to the dorsal aspect of the wrist. The pain is aggravated with extended repetitive use of the right upper extremity, lifting heavy objects and forceful gripping. Pain is relieved by rest.
Objectively the claimant has visual swelling relative to the contralateral side. There are three well-healed surgical incisions about the dorsal aspect of the wrist. On palpation, the claimant is mildly tender to palpation about the dorsal aspect of the wrist. Active range of motion is limited in the right wrist. Finkelstein's is weakly positive.
Medical records were reviewed.
After reviewing records from Dr. [redacted] and Dr. [redacted] in my opinion, the following formal work restrictions are appropriate for this claimant at this time. the claimant is not to lift, pull or push greater than 15-pounds with the right upper extremity. The claimant is to limit keyboarding to no more than two hours per work shift. The claimant is to self-modify her duties as deemed appropriate. I have a low threshold for adding further duty modifications or, if appropriate, removing duty preclusions going forward.
Assessment includes (1) status post multiple surgical procedures of the right wrist and (2) major depressive disorder.
The claimant's treatment plan includes getting the claimant back to work. Wean off cyclobenzaprine, continue venlafaxine, and continue NSAID medication as prescribed. Continue psychotherapy with Dr. [redacted] Continue current prescribed course of physical therapy. Return in six weeks for repeat evaluation.

Request for authorization for continuous medical necessity treatment/medications to cure or relieve the effect of the industrial injury.

[redacted] M.D. – [redacted] MD, Inc, QME Electrodiagnostic Medicine – In reply to the request for a supplemental report regarding the claimant's limitations of ADLs due to her scar, when I saw the claimant she had

pain in the right hand that hurt most over the extensor compartment of the right wrist in a partial wrist C-like distribution. She complained of a deep aching, throbbing, tingling, burning, radiating, and numb pain to the right thumb on the right side only. The pain makes it hard for her to write and type. There is numbness and burning inside her wrist. She cannot sleep at night because of this. The pain is there all of the time and is worse with use of over a minute. The pain is better with rest.

The claimant has a hard time driving with the right hand and holding onto the steering wheel with both hands. Using a computer, mousing, typing, showering, bathing, doing ADLs, wiping after a bowel movement, and holding a book are difficult as any use of the right hand causes pain. She also has numbness and tingling.

On the extension component of the examination there were symptoms at the incision site which was also hypertrophic measuring 2x0.5cm with a hardness induration and palpable scar tissue. There were some superficial abrasions from sutures on the extensor compartment of the wrist with a lot of swelling over that area measuring 3x1cm and they looked like three separate parallel scratches. On the extensor compartment of the thumb area, there was hypertrophy and another scar measuring 1.5x0.5cm with palpable scar tissue that was indurated and hard.

The left elbow had an incision with mild hypertrophy at the ends of it measuring 5cm in its length and almost 1cm at its greatest width. There was diffuse swelling about the right extensor component of the wrist of both hands.

[redacted] – [redacted] Medical Clinic, Inc., Mental Health Progress Report – Subjectively the claimant reported that she returned to work in her prior position in May, after accommodations were worked out, and that lifted a large amount of her stress. However, over time the stresses associated with her injury have taken a toll on her relationship with her partner. The claimant notes that she is now working on this and that it has been helpful to work with psychology to assist in emotional readiness for return to work. The claimant's affect was euthymic, mildly stressed because she was working on her day off and covering for someone caused her to be late to the appointment. Setting boundaries and goals for committing herself to adequate self-care was discussed. An app was discussed to help manage stress.

Objectively the claimant appears to be benefitting from therapy and is beginning to show resilience as she starts back to work, but will benefit from ongoing work with stress management.

Her Beck Depression Inventory was 17, suggesting a borderline level of depressive symptoms.

On the BAI she received a score of 5, which was equal to her score in [redacted] and does not suggest a clinical significant level of anxiety.

She also completed the Pain Catastrophizing Scale and received a score of 12,

which does not suggest a clinical significant pain catastrophizing level.
Medical records were reviewed.
DSM Diagnosis was major depressive disorder, single, mild.
Treatment plan was to continue additional sessions.

[redacted] claims representative – Letter to Dr. [redacted] – The claimant was provided an ergonomic evaluation and recommended equipment was purchased and provided for her use during her working hours. After one month, it is noted that there was a small issue with the system compatibility with the claimant's new ergonomic equipment and the issue was resolved.
Ms. [redacted] is requesting an assessment of the claimant's work status, now that she has been using the ergonomic equipment, in relation to her essential functions list.

[redacted] – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – Claimant reports for follow-up and notes that she has been increasing her work load due to lack of staff at work. She feels her right upper extremity pain is worse. Paraffin home instruction has been authorized. Additional CBT with Dr. [redacted] has also been authorized.
Subjectively the claimant continues to report wrist pain, described as aching pain with level at 4/10. Decreased range of motion with tenderness to palpation near the radial styloid over the scar.
The claimant is status post right DeQuervain's release on [redacted] and status post excision of right dorsal wrist ganglion on [redacted] with Dr [redacted]
Objectively the claimant has right thumb pain, sleep disturbance, DeQuervain's tenosynovitis, and depression.
Dr. [redacted] recommended stretching, HEP, and trying to do computer work under restrictions. Continue CBT, continue conservative care, complete PT, and take off work for 1 week until follow-up with PTP for work status change.

[redacted] – State of California Division of Workers' Compensation, Primary Treating Physician's Progress Report – Subjectively the claimant reports worsening of right wrist pain.
Objectively the claimant has tenderness to palpation, but well healed surgical incisions.
Diagnoses included (1) DeQuervain's tenosynovitis and (2) depression, major, not specified.
Treatment plan is to continue current restrictions and medications. The claimant is to remain off work until [redacted]

[redacted] – [redacted] Medical Inc., Work Status Form – Total temporary disability from [redacted] to [redacted].

[redacted], Inc., Confidential Psychological Progress Note – The claimant describes her mood as up and down. Changes at work due to workload and staffing have made it difficult for her to perform her job duties. She is currently off work until [redacted] per Dr. [redacted] order. The claimant is frustrated and sad about not being able to return like she thought. Affect was somewhat stressed and mildly sad. Supportive therapy was provided to help her recognize that stress was coming in the form of uncertainty about her future as well as potential loss of her career. Her feelings were normalized with cognitive restructuring and setting expectations.
DSM Diagnosis was major depressive disorder, single, mild.
Her expected outcome was stabilization and improvement of her functioning, preventing further decline, and relieving/improving distressing symptoms.
Treatment plan included continued sessions.

[redacted], M.D. – [redacted] MD, Inc. – QME, Electrodiagnostic Medicine – In reply to the supplemental request, I reviewed the [redacted] work site evaluation, Dr. [redacted] and [redacted] reports and [redacted] job description, Ms. [redacted] needs the recommendations of [redacted] to continue working. otherwise, I agree with her physicians, who agree with my restrictions.

[redacted] – [redacted] Medical Clinic, Inc., Physician's Progress Report – Chief complaint of right hand pain with injury date of [redacted]
Subjectively the claimant complains of right hand and wrist pain, graded at 7/10, for the last three years.
Physical examination reveals crepitus noted over the right wrist joint with tenderness to palpation.
Diagnosis was tendonitis of the right wrist.
Treatment plan was to continue over-the-counter NSAIDs and paraffin baths. The claimant has been instructed to remain off-work until [redacted]

[redacted], [redacted] – [redacted] Medical Clinic Inc., Confidential Psychological Progress Note – The claimant reported her mood as nervouse and has been up and down with pending retirement dates scheduled for [redacted] Affect was appropriate to conversation and ranged from mildly sad to reflective.
DSM diagnosis was major depressive disorder, single episode, mild.
Expected outcome was noted as stabilize and improve functioning, prevent further decline in functioning, and relive or improve distressing symptoms.
Treatment recommendations include evaluating to determine level of symptoms and appropriate treatment moving forward at the next session.

[redacted] XXXXXX XXXXX, claimant- XXXXXX Authorization to Disclose Protected Health Information. Signed by the claimant.

[redacted] XXXXXX XXXXX, claimant – XXXXXX Disability Retirement Election Application – The claimant was injured on the job by repetitive use of the computer and keyboarding. She is currently limited in use of her right wrist. The claimant can only be on the computer for less than 15-minutes at a time. she cannot perform her regular duties due to the swelling or burning sensation aggravating her wrist and also cannot write for more than two minutes without pain and discomfort. the claimant is works full-time, however, is not currently working in any capacity. The claimant's current job duties are 90% computer based. The claimant lists her treating physician as occupational medicine doctor, [redacted].

[redacted] [redacted]. – [redacted] Medical Clinic, Inc. – XXXXXX Physician's Report on Disability – The claimant worked as a XXXX [redacted] and is claiming injury on [redacted] with last date of work being [redacted]. The claimant was first seen by the examiner on [redacted]. The injury is claimed to be work related from repetitive trauma.
Examination findings include pain of the right upper extremity with limited range of motion, pain, and weakness of the right hand.
Diagnosis made is status post multiple right hand surgeries with well healed surgical incisions. MRI of the right hand on [redacted] revealed a ganglion cyst. The claimant is limited to no repetitive use of the right hand.
The claimant's incapacity is permanent. She is unable to use a keyboard or mouse.
The job duty statement/job description as well as physical requirements of position/occupation were reviewed.

[redacted] [redacted]. – [redacted] Medical Clinic Inc., Physician's Progress Report – Chief complaint is right hand pain. Date of injury is [redacted]
Subjectively the claimant has been experiencing this pain for three years. Her pain is 5/10. The right hand pain is unchanged.
Physical examination reveals crepitus over the right wrist joint with tenderness to palpation. The range of motion is also decreased.
Diagnoses are (1) tendonitis of the right wrist and (2) history of hand surgery.
The treatment plan was to continue her current medications. She is permanent and stationary per AME. Follow-up as needed.

End of Report.

LACERA

October 30, 2017

FOR INFORMATION ONLY

TO: Disability Procedures and Services Committee
Vivian Gray, Chair
Marvin Adams, Vice Chair
Alan Bernstein
Ronald Okum
David Muir, Alternate

FROM: Ricki Contreras, Division Manager RC
Disability Retirement Services

FOR: November 9, 2017 Disability Procedures and Services Committee

SUBJECT: Aging Report on Cases Older than 18 Months

At the Board of Retirement meeting on October 12, 2017, Mr. Muir requested a list of all pending cases that are 18 months or older. Attached is an Aging Case Report which lists each of the 36 cases (approximately .5% of the total pending cases) that are 18 months or older as of the date of this report.

In order to protect member privacy, each case is listed by date of application and has been assigned a category which outlines reasons for the delay in each case. Additionally, more specific case details and current status are also provided to highlight the most relevant delays.

Please refer to the table below for category definitions and processing times prior to reviewing the attached Aging Case Report.

Case Category	Category Definitions – Typical Elements of Case	Processing Time
Standard	Clear well-documented injury or condition within one specialty usually without any complicating accommodation issues.	9-12 months

Multi-Condition	Required multiple examinations, fair to moderately documented injuries/conditions, but may have other overlapping conditions, in multiple specialties. May also include non-industrial conditions.	12-18 months
Complex	A complex case may contain one or more the following elements: • Request for a Salary Supplement • Accommodation Issues • Request for a Job Analysis • Personnel Issues/Termination for Cause • Fitness for Duty • Legal or Eligibility Issues/Requires Legal Opinion • Psychiatric Component • Overlapping medical conditions, including non-industrial conditions • Employer Filed Applications	12-24+ months
Problematic	A problematic case poses challenges that are outside of Disability Retirement Service's control and may contain one or more of the following elements: • Difficulty locating records/documents • Member cooperation challenges • Poor response time from department • Poor response time obtaining records; despite continual follow-up. • Deterioration of condition or death of member. • Extensive clarification needed from panel physicians including multiple requests for supplemental reports. • Extensive clarification needed from departments including return to work/supervisor/DHR • May require legal counsel intervention including legal opinion	12-24+ months

	• Case reassigned due to DRS Staff unscheduled, extended medical leave of absence	

Additionally, please note staff actively manages each case on a monthly basis, or in some cases, on an agreed upon time frame based on the specific circumstances of each case.

There are occasions where staff hold a case in abeyance at the request of the member or department based on specific circumstances. For example, salary supplements, permanent accommodation determinations, amending for an additional condition, inability to travel, or a member's refusal to cooperate. Staff is currently considering options which may limit the number of delays which can be approved during the duration of the application. We expect to bring some policies to the Committee, for consideration, that explicitly categorizes special circumstance cases based on pre-defined acceptable reasons for delay so that we may track these cases separately from our standard processing category as defined above, and/or limit the duration these cases may remain open.

Attachments

JJ:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

Aging Case Report
18 Months and Older

Application Date	Dept.	Category	Elapsed Time	Case Detail/Status
9/25/2014	RP	Multi-Condition, Problematic	37	Required 2 exams (Orthopedic and Neurological) Active death during process **Status:** Beneficiary has not determined whether to proceed with case as of 7/14/17
1/12/2015	MH	Multi-Condition, Problematic	33	Reassigned Case Multi-Condition (Orthopedic and Internal) Member cooperation challenges **Status:** Multiple attempts to reach member unsuccessful; phone disconnected; Skiptracing efforts initiated as of 10/30/17
1/8/2015	FR	Complex, Problematic	33	Salary Supplement - delay in finding position; position located, but no vacancy available, additional positions were identified **Status:** Member currently being trained for identified position as of 6/15/17; then must apply for vacancy
2/17/2015	PB	Multi-Condition, Problematic	32	Department response challenges Member having difficulty securing Physician Statement for 2nd condition **Status:** Pending amendment from member for 2nd condition as of 7/17/17
5/18/2015	HS	Multi-Condition, Problematic	29	Reassigned case Required 2 exams Required 2 supplemental reports **Status:** Pending legal review for December Agenda
7/14/2015	FR	Multi-Condition, Problematic	27	Required 3 exams (Cardiology, Neurological, and Orthopedic) Required 1 supplemental report **Status:** Pending Accommodation Response as of 10/10/17 with follow up 10/20/17
7/15/2015	SS	Complex, Problematic	27	Reassigned case Non-industrial injury that impact claim was uncovered post-exam Additional records were requested Required 1 supplemental report **Status:** Pending supplemental report as of 10/16/17
7/22/2015	PB	Complex, Problematic	27	Salary Supplement - delay in finding position Department response challenges **Status:** Position Identified; Pending Exam Scheduling as of 10/19/17
8/5/2015	AO	Complex, Problematic	26	Salary Supplement - delay in finding position Required 1 supplemental report **Status:** Supplemental report received 10/27/17; Accomodation Request in Process

Aging Case Report
18 Months and Older

Application Date	Dept.	Category	Elapsed Time	Case Detail/Status
9/14/2015	PB	Complex, Problematic	25	Salary Supplement - delay in finding position Department response challenges **Status:** Pending Identification of New Position as of 3/16/17
9/15/2015	HO	Multi-Condition, Problematic	25	Required 2 exams (Orthopedic and Psychiatric) Member cooperation challenges **Status:** Pending Investigator Report as of 10/30/17
9/17/2015	MH	Problematic	25	Required 2nd orthopedic exams (Dr. Fenton case) Member cooperation challenges **Status:** Pending meeting with executive and DRS management staff as of 9/11/17
10/27/2015	AU	Complex, Problematic	24	Fitness for Duty case Salary Supplement - delay in finding position Civil lawsuit pending DHR Risk Management requested to delay **Status:** Position Identified; Pending Exam as of 9/19/17
11/23/2015	SH	Complex, Problematic	23	Employer Application Required 2 supplemental reports Required Job Analysis Legal Counsel requested additional records **Status:** Pending Legal Recommendation as of 10/12/17
11/30/2015	CH	Complex, Multi-Condition, Problematic	22	Required 2 exams (Orthopedic and Psychiatric) Difficulty obtaining records **Status:** November Agenda
12/4/2015	PK	Multi-Condition	22	Reassigned case Multi-Condition (Internal and Orthopedic) Case prepared for BOR; member amended 1 day prior to Board, case pulled **Status**: Investigating 2nd condition as of 9/6/17
1/11/2016	SH	Multi-Condition	21	Required 2 exams (Orthopedic and Internal) **Status:** Pending 2nd Exam as of 10/31/17
2/8/2016	HM	Multi-Condition, Problematic	20	Required 2 supplemental reports Department response challenges **Status:** Investigating 2nd condition as of 9/21/17
2/5/2016	SH	Problematic	20	Employer Application BOR remanded back to staff for supplemental report **Status:** November Agenda

Aging Case Report
18 Months and Older

Application Date	Dept.	Category	Elapsed Time	Case Detail/Status
2/19/2016	PB	Multi-Condition, Problematic	20	Reassigned Case Member having difficulty securing Physician Statement for 2nd condition **Status:** Prepping for December agenda
2/16/2016	CH	Complex, Problematic	20	Psychiatric case Member cooperation challenges Active death during process **Status:** Pending Investigator Report as of 10/13/17; record review only
2/23/2016	CH	Multi-Condition, Problematic	20	May require 2 exams (Orthopedic and Internal) Additional information provided post initial exam Required 1 supplemental report **Status:** Pending accommodation form as of 10/18/17
2/1/2016	SH	Complex, Problematic	20	Required 1 supplemental report Panel physician delay due to travel May required additional exams (psychiatric and hearing) **Status:** Prepping for December agenda
2/3/2016	SH	Complex, Problematic	20	Fitness for Duty case Member cooperation challenges/Member also lives out of state Record challenges **Status:** Exam Scheduled for 12/6/17
2/16/2016	CH	Complex, Multi-Condition, Problematic	20	Reassigned case Multi-Condition (Orthopedic and Internal) Large volume of records; panel physician requested more time Required 1 supplemental report **Status**: Pending 2nd Exam as of 9/28/17
2/1/2016	CH	Problematic	20	Employer Application Department response challenges Member cooperation challenges - went out of the country prior to exam **Status:** Exam Scheduled for 12/14/17
3/10/2016	SC	Complex, Problematic	19	Reassigned case Member cooperation challenges **Status:** Pending Legal Recommendation for December Agenda
4/22/2016	PB	Complex	18	Salary Supplement - delay finding position **Status:** November Agenda

Aging Case Report
18 Months and Older

Application Date	Dept.	Category	Elapsed Time	Case Detail/Status
4/11/2016	IS	Complex, Problematic	18	Member cooperation challenges Required Job Analysis **Status:** Exam Scheduled for 10/30/17
4/25/2016	SH	Problematic	18	Member cooperation challenges - delay interview and medical evaluation **Status:** Pending department response regarding accommodation as of 10/24/17
4/18/2016	CH	Complex, Problematic	18	Multi-condition overlay Required 1 supplemental report **Status:** November Agenda
3/28/2016	FR	Complex, Problematic	18	Retirement in Lieu of Termination Case Challenges obtaining witness statements **Status:** Pending Investigator Report as of 9/13/17
4/5/2016	CH	Complex, Problematic	18	Psychiatric case Member cooperation challenges and language barriers Challenges obtaining records **Status:** Pending Investigator Report as of 9/20/17
3/29/2016	PS	Problematic	18	Reassigned case Panel physician delay; cancellation Member cooperation challenges **Status:** Pending accommodation response as of 10/17/17
3/29/2016	HG	Problematic	18	Reassigned case Member cooperation challenges **Status:** Pending Interview as of 10/23/17
4/15/2016	CH	Complex, Problematic	18	Reassigned Case Required Job Analysis Required 1 Supplemental report **Status:** November Agenda