IN PERSON & VIRTUAL BOARD MEETING

JANUARY 4, 2023 AT 9:00 AM
BOARD OF RETIREMENT MEETING

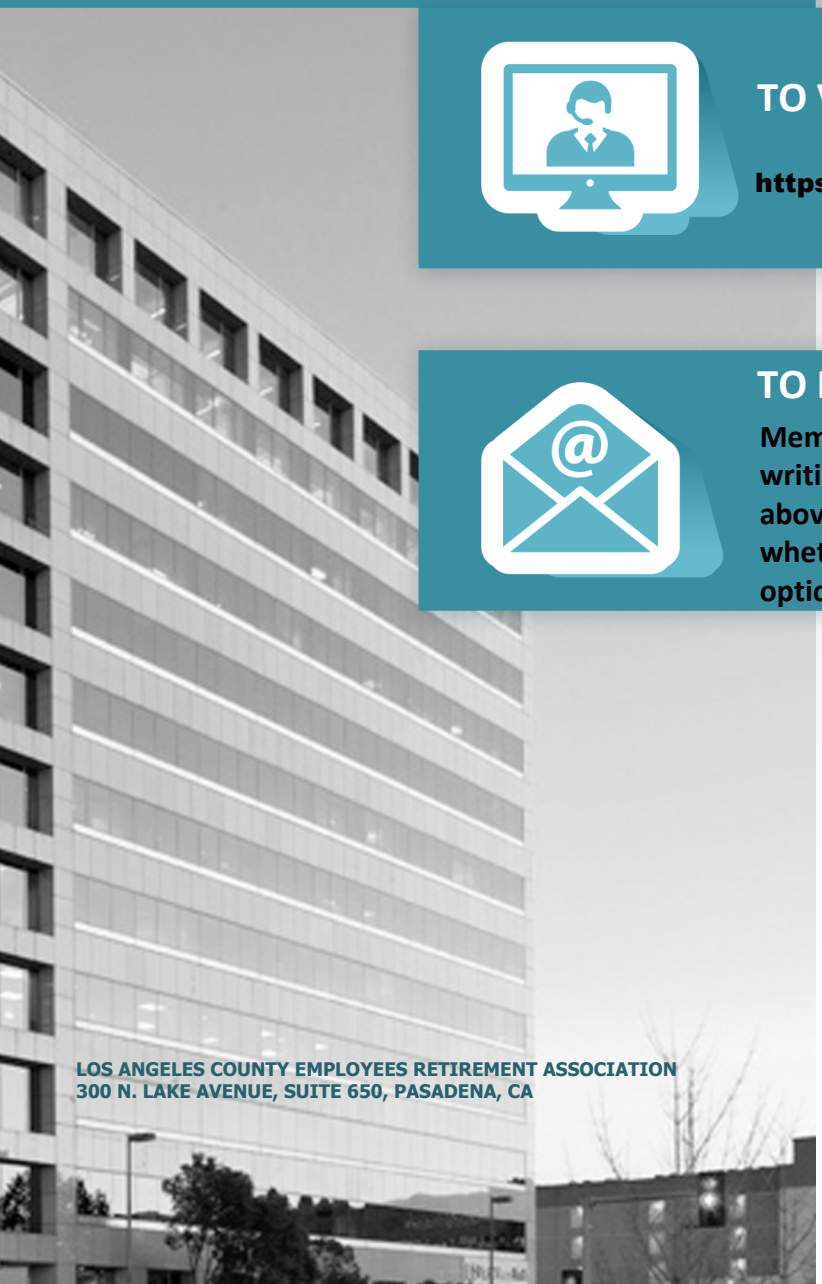
TO VIEW VIA WEB

https://lacera.com/leadership/board-meetings

TO PROVIDE PUBLIC COMMENT

Members of the public may address the Board orally and in writing. To provide Public Comment, you should visit the above link and complete the request form by selecting whether you will provide oral or written comment from the options located under Options next to the Board meeting.

Attention: If you have any questions, you may email PublicComment@lacera.com. If you would like to make a public comment during the board meeting, review the Public Comment instructions.



LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION
300 N. LAKE AVENUE, SUITE 650, PASADENA, CA

AGENDA

A REGULAR MEETING OF THE BOARD OF RETIREMENT

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

9:00 A.M., WEDNESDAY, JANUARY 4, 2023*

This meeting will be conducted by the Board of Retirement both in person and by teleconference under California Government Code Section 54953(e).

Any person may view the meeting in person at LACERA's offices or online at https://LACERA.com/leadership/board-meetings

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

NOTICE: Pursuant to FPPC Regulation 18702.5, this statement provides notice, before elections take place, that appointed trustees, the retired trustee, and the alternate retired trustees when elected or appointed to a committee will receive a stipend of $100 per meeting attended, up to a total of $500 per month for all Board of Retirement and committee meetings attended during the term of their appointment. Upon completion of today's election and the Chair's appointment of other committee members, LACERA will post Form 806 on lacera.com to provide public notice of the fees to be received by such trustees. Active general and safety member elected trustees, the ex-officio trustee, and the alternate ex-officio do not receive compensation for attending LACERA Board and committee meetings, other than their regular salary as County employees. All trustees receive reasonable and necessary expenses.

Appointed trustees to the Board of Retirement are Alan J. Bernstein, Elizabeth Greenwood, Antonio Sanchez, and Ronald Okum. The retired trustee is Les Robbins. The alternate retired trustee is James P. Harris. The active general and safety member elected trustees are Vivian H. Gray, Jason E. Green, Shawn R. Kehoe (alternate safety), and Herman B. Santos. The ex-officio member is Keith Knox, and the alternate ex-officio is Elizabeth B. Ginsberg.

I. CALL TO ORDER

II. RATIFICATION OF OFFICERS

A. **Board Officers: 2023 Calendar Year**
Recommendation as submitted by Santos H. Kreimann, Chief Executive Officer: That the Board ratify its slate of board officers who will serve their term in the 2023 calendar year: Les Robbins as Chair, Alan J. Bernstein as Vice Chair, and Shawn R. Kehoe as Secretary. (Memo dated December 19, 2022)

III. ELECTIONS OF COMMITTEE MEMBERS
Election of Trustees to Joint Organizational Governance Committee (1 Trustee) and Audit Committee (3 Trustees)

IV. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of December 7, 2022

V. PUBLIC COMMENT
(Members of the public may address the Board orally and in writing. To provide Public Comment, you should visit https://LACERA.com/leadership/board-meetings and complete the request form by selecting whether you will provide oral or written comment from the options located under Options next to the Board meeting.

If you select oral comment, we will contact you via email with information and instructions as to how to access the meeting as a speaker. You will have up to 3 minutes to address the Board. Oral comment request will be accepted up to the close of the Public Comment item on the agenda.

If you select written comment, please input your written public comment or documentation on the above link as soon as possible and up to the close of the meeting. Written comment will be made part of the official record of the meeting. If you would like to remain anonymous at the meeting without stating your name, please leave the name field blank in the request form. If you have any questions, you may email PublicComment@lacera.com.)

VI. EXECUTIVE UPDATE

A. LACERA All Stars

B. Awards

C. Chief Executive Officer's Report – January 2023

VII. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

VIII. CONSENT ITEMS

A. **Approval of the Use of Teleconference Meeting**
Recommendation as submitted by Steven P. Rice, Chief Counsel: That, under AB 361 and Government Code Section 54953(e)(3) of the Brown Act, the Board of Retirement and Board of Investments separately consider whether to find that the Governor's COVID-19

VIII. CONSENT ITEMS (Continued)

State of Emergency continues to directly impact the ability of each Board and its Committees to meet safely in person and that other public agencies still recommend social distancing such that each Board and its Committees shall hold teleconference meetings for the next 30 days as part of hybrid meetings also in person, so long as the State of Emergency remains in effect, and direct staff to comply with the agenda and public comment requirements of Section 54953(e)(3). Action taken by each Board will only apply to that Board and its Committees. (Memo dated December 21, 2022)

B. **Ratification of Service Retirement and Survivor Benefit Application Approvals**
Service retirements and survivor benefit applications received as of December 27, 2022, along with any retirement rescissions and/or changes approved at last month's Board meeting.
(Memo dated December 27, 2022)

C. **Federal Engagement: Visit with Congress**
Recommendation as submitted by Les Robbins, Chair, Insurance, Benefits and Legislative Committee: That the Board 1) Approve a visit with Congress by Board trustees as designated by the Chair of the Board of Retirement and by staff as designated by the Chief Executive Officer during the week of January 22, 2023 in Washington, D.C.; and 2) Approve reimbursement of all travel costs incurred in accordance with LACERA's Trustee Travel Policy.
(Memo dated December 20, 2022)

D. **Compensation Earnable and Pensionable Compensation**
Recommendation as submitted by Fern M. Billingy, Senior Staff Counsel: 1) That the Board Adopt the Attached Resolutions, No. 2023-BR001, and No. 2023-BR002, specifying pay items as included and excluded from the definitions of "compensation earnable" and "pensionable compensation." 2) Instruct staff to coordinate with the County of Los Angeles to establish necessary reporting mechanism and procedures to permit LACERA to include or exclude these items when calculating final compensation.
(Memo dated December 19, 2022)

VIII. CONSENT ITEMS (Continued)

E. **Consider Applications for LACERA Panel of Examining Physicians**
Recommendation as submitted by Ricki M. Contreras, Division Manager, Disability Retirement Services: That the Board approve the Applications of Osep E. Armagan, M.D. – Orthopedic; Jesse Carr, M.D. – Psychiatry; Divakar Krishnareddy, M.D. – Orthopedic; Richard C. Rosenberg, M.D. – Orthopedic; and Gabor Vari, M.D. – Psychiatry to the LACERA Panel of Examining Physicians.
(Memo dated December 22, 2022)

F. **Dismiss with Prejudice the Appeal of Barbara C. Yu**
Recommendation as submittedby Ricki M. Contreras, Division Manager, Disability Retirement Services: That the Board dismiss with prejudice Barbara C. Yu's appeal for a service-connected disability retirement. (Memo dated December 23, 2022)

G. **Appeal for the Board of Retirement's Meeting of January 4, 2023**
Recommendation as submitted by Ricki M. Contreras, Division Manager, Disability Retirement Services: That the Board grant the appeal and request for administrative hearing received from the following applicant and direct the Disability Retirement Services Manager to refer this case to a referee: Frances M. Govens.
(Memo dated December 23, 2022)

IX. EXCLUDED FROM CONSENT ITEMS

X. NON-CONSENT ITEMS

A. **AB 2449 Teleconference Meeting Procedures**
Recommendation as submitted by Steven P. Rice, Chief Counsel: That the Board discuss and provide input on the implementation process for the AB 2449 teleconference meeting procedures that may be used in preparing a policy for consideration by the Board of Retirement at a future meeting. (Memo dated December 19, 2022)

B. **Reimbursement of Trustee Accommodation Expenses**
Recommendation as submitted by Santos H. Kreimann, Chief Executive Officer: That the Board consider whether to allow

X. NON-CONSENT ITEMS (Continued)

reimbursement of hotel accommodation expenses for travel to scheduled Board or Committee meeting to Trustees who reside more than two to three hours, or other time and distance, from the regular place of the meetings in Pasadena, California.
(Memo dated December 20, 2022)

C. **Retirement Date Adjustment**
Recommendation as submitted by Louis Gittens, Interim Benefits Division Manager and Allan Cochran, Member Services Division Manager: That the Board of Retirement approve the adjustment of Former Supervisor Sheila Kuehl's date of retirement to December 6, 2022. (Memo dated December 20, 2022)

XI. REPORTS

A. **State Legislative Update**
Shari McHugh, Legislative Advocate, McHugh Koepke & Associates
Naomi Padron, Legislative Advocate, McHugh Koepke & Associates
(Presentation) (Memo dated December 22, 2022)

B. **Application Processing Time Snapshot Reports**
Ricki M. Contreras, Division Manager
(For Information Only) (Memo Dated December 22, 2022)

C. **Trustee Travel & Education Reports – November 2022**
Ted Granger, Interim Chief Financial Officer
Monthly Trustee Travel & Education Report – November 2022
(For Information Only) (Memo dated December 21, 2022)
Comprehensive Monthly Trustee Travel & Education Report – November 2022 (Confidential memo dated December 21, 2022 – Includes Pending Travel)

D. **December 2022 Fiduciary Counsel Report**
Steven P. Rice, Chief Counsel
(For Information Only) (Memo dated December 20, 2022)
(Privileged and Confidential/Attorney-Client Communication/Attorney Work Product)

XII. ITEMS FOR STAFF REVIEW
(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agendized item at a future meeting.)

XIII. ITEMS FOR FUTURE AGENDAS
(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

XIV. GOOD OF THE ORDER
(For Information Purposes Only)

XV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability

B. Disability Retirement Appeals

C. Staff Recommendations

1. **Bethly Mills – Recommendation to Dismiss Application**
Recommendation as submitted by Jason Waller, Senior Staff Counsel, Disability Litigation: That the Board, pursuant to Government Code section 31720, 1) determine that Bethly Mills is not incapacitated from her duties as a Nursing Attendant I, based upon Dr. Kenneth Scheffels' July 9, 2021, medical evaluation and the Department of Health Services' confirmation they can accommodate Ms. Mills' work restrictions, and 2) dismiss her Application for Service-Connected Disability Retirement without Prejudice, as she is currently working her usual and customary job duties. (Memo dated December 19, 2022)

2. **Service Provider Invoice Approval Request – Robert A. Moore, M.D.**
Recommendation as submitted by Ricki M. Contreras, Division Manager, Disability Retirement Services: That the Board approve the service provider invoice for Robert A. Moore, M.D. (Memo dated December 23, 2022)

XV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

C. Staff Recommendations (Continued)

3. **Service Provider Invoice Approval Request – Seymour Levine, M.D.**
Recommendation as submitted by Ricki M. Contreras, Division Manager, Disability Retirement Services: That the Board approve the service provider invoice for Seymour Levine, M.D.
(Memo dated December 23, 2022)

XVI. ADJOURNMENT

Although the meeting is scheduled for 9:00 a.m., it can start anytime thereafter, depending on the length of the Committee meeting preceding it.

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

Requests for reasonable modification or accommodation of the telephone public access and Public Comments procedures stated in this agenda from individuals with disabilities, consistent with the Americans with Disabilities Act of 1990, may call the Board Offices at (626) 564-6000, Ext. 4401/4402 from 8:30 a.m. to 5:00 p.m. Monday through Friday or email PublicComment@lacera.com, but no later than 48 hours prior to the time the meeting is to commence.

MINUTES OF THE REGULAR MEETING OF THE BOARD OF RETIREMENT

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

9:00 A.M., WEDNESDAY, DECEMBER 7, 2022

This meeting was conducted by the Board of Retirement both in person and by teleconference under California Government Code Section 54953(e).

PRESENT: William Pryor (Alternate Safety), Chair (In-Person)

Shawn R. Kehoe, Vice Chair (Teleconference)

Alan Bernstein, Secretary (In-Person)

Keith Knox (In-Person)

Vivian H. Gray (Teleconference)

JP Harris (Alternate Retired) (Teleconference)

Wayne Moore (In-Person)

Les Robbins (Teleconference)

Antonio Sanchez (Teleconference)

Herman Santos (Teleconference)

ABSENT: Elizabeth Greenwood

STAFF ADVISORS AND PARTICIPANTS

Santos H. Kreimann, Chief Executive Officer

Luis A. Lugo, Deputy Chief Executive Officer

Jonathan Grabel, Chief Investment Officer

JJ Popowich, Assistant Executive Officer

Laura Guglielmo, Assistant Executive Officer

STAFF ADVISORS AND PARTICIPANTS (Continued)

Steven P. Rice, Chief Counsel

Francis J. Boyd, Senior Staff Counsel

Jasmine Bath, Senior Staff Counsel

Elain Salon, Staff Counsel

Dr. Glenn Ehresmann, Medical Advisor

Ted Granger, Interim Chief Financial Officer

Barry W. Lew, Legislative Affairs Officer

Kathy Delino, Systems Interim Chief Information Technology Officer

Louis Gittens, Benefits Interim Division Manager

Carly Ntoya, Human Resources Director

Ricki Contreras, Disability Retirement Manager

Tamara Caldwell, Disability Retirement Specialist Supervisor

Vickie Neely, Disability Retirement Specialist Supervisor

Kerri Wilson, Disability Retirement Specialist Supervisor

Hernan Barrientos, Disability Retirement Specialist Supervisor

Ricardo Salinas, Disability Retirement Specialist Supervisor

Vincent Lim, Disability Litigation Manager

Anthony Roda, Legislative Advocate, Williams & Jensen

Shane Doucet, Legislative Advocate, Doucet Consulting

I. CALL TO ORDER

The meeting was called to order by Chair Pryor at 9:00 a.m.

II. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of November 2, 2022

Mr. Knox made a motion, Mr. Kehoe seconded, to approve the minutes of the Regular meeting of November 2, 2022. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

III. PUBLIC COMMENT

There were no requests from the public to speak.

IV. EXECUTIVE UPDATE

A. For Information

1. LACERA All Stars

Mr. Popowich announced the winners for the month: Nicole Howard, David Escamilla, Miguel Rodriguez, and Judith Cajulis. The Rideshare winner was Gloria Colorado.

2. Chief Executive Officer's Report
(Memo dated November 29, 2022)

Mr. Lugo provided an update to the strategic planning efforts, as well as hiring efforts and upcoming recruitments. Furthermore, he provided an update to the OneMeeting meeting management solution and upcoming training opportunities for Trustees. Lastly, Mr. Lugo recognized Trustees Moore, Zapanta, and Pryor for

IV. EXECUTIVE UPDATE (Continued)

their service on the Board.

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Law Enforcement
Service-Connected Disability Applications

On a motion by Mr. Kehoe, seconded by Mr. Robbins, the Board of Retirement approved a service-connected disability retirement for the following named employees who were found to be disabled for the performance of their duties and have met the burden of proof. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

APPLICATION NO.	NAME
835D	FRANK T. MONTEZ, JR.
836D	MICHAEL S. BAKER
837D	RALPH HERNANDEZ
838D	SARA CLEVELAND
839D	MYKEL A. TRUJILLO
840D	TROY E. SELLA
841D	TONY T. BOWIE
842D	RODNEY D. MARTIN, JR.
843D	JOHN S. BONES
844D	BRYAN C. FREEL

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Law Enforcement (Continued)
Service-Connected Disability Applications

APPLICATION NO.	NAME
845D	SEAN C. WALTERS
846D	EDWARD S. GILPIN
847D	JAMES G. WALKER
848D	MICHAEL RAMOS
849D	DONOVAN H. GABBEDON
850D	DAVID C. LUTHER
851D*	NORMA MACIEL
852D	RICK A. THURLO
853D	DANIEL E. ESTRADA
854D	PAUL N. KOSZUT
855D	NICHOLAS D. NERI
856D	JENNY LEE
857D	HOWARD J. COOPER
858D**	WILLIAM R. MURRAY
859D	JOHN W. SANDS
860D	JOHN P. FINLEY

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

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Fire, Lifeguards
Service-Connected Disability Applications

On a motion by Mr. Pryor, seconded by Mr. Kehoe, the Board of Retirement approved a service-connected disability retirement for the following named employees who were found to be disabled for the performance of their duties and have met the burden of proof. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

APPLICATION NO.	NAME
1540B	ROBERT F. OTANEZ
1541B	SHAWN YOUNGMAN
1542B	MICHAEL J. CANNIZZARO
1543B	JAMES E. ROY
1544B	RONALD A. HORETSKI
1545B	NANCY L. IACONO
1546B	KENNETH J. FERNANDEZ
1547B	MICHAEL J. FITZPATRICK
1548B	ULYSSES DURAN
1549B	RUBEN RUVALCABA
1550B	CHRIS C. FROHOFF
1551B*	ADOLFO PEREZ

*Granted SCD – Retroactive

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

General Members
Service-Connected Disability Applications

On a motion by Mr. Bernstein, seconded by Ms. Gray, the Board of Retirement made a motion to approve a service-connected disability retirement for the following named employees who were found to be disabled for the performance of their duties and have met the burden of proof. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

APPLICATION NO.	NAME
2469C	APRIL P. GINGRAS
2470C*	DONNA M. HUGGINS
2471C	ERLINDA C. MEDINA
2472C**	JENIFEER E. LARA
2473C*	CARYN LEUSCHNER
2474C	CAROLYN LAPOINTE
2475C***	DIANA L. SOLIS
2476C****	CYNTHIA SNYDER-GARNER
2477C***	PATRICIA E. GUARDADO
2478C****	ADAM CARRILLO

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

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

General Members (Continued)
Service-Connected Disability Applications

APPLICATION NO.	NAME
2479C*	JOSE S. SANCHEZ (DEC'D)
2480C**	MARIA G. LOERA
2481C***	ROGER P. HUMBARGER

General Members
Nonservice-Connected Disability Applications

On a motion by Ms. Gray, seconded by Mr. Knox, the Board of Retirement made a motion to approve a service-connected disability retirement for the following named employees who were found to be disabled for the performance of their duties and have met the burden of proof. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

APPLICATION NO.	NAME
4415****	MARIA R. PEREZ

*Granted SCD Survivor Benefit
**Granted SCD - Employer Cannot Accommodate
***Granted SCD - Retroactive Employer Cannot Accommodate
****Granted NSCD – Retroactive

VI. CONSENT ITEMS

Mr. Knox made a motion, Ms. Gray seconded, to approve Consent Items A-E. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

A. Recommendation as submitted by Steven P. Rice, Chief Counsel: That, under AB 361 and Government Code Section 54953(e)(3) of the Brown Act, the Board of Retirement and Board of Investments separately consider whether to find that the Governor's COVID-19 State of Emergency continues to directly impact the ability of each Board and its Committees to meet safely in person and that other public agencies still recommend social distancing such that each Board and its Committees shall hold teleconference meetings for the next 30 days as part of hybrid meetings also in person, so long as the State of Emergency remains in effect, and direct staff to comply with the agenda and public comment requirements of Section 54953(e)(3). Action taken by each Board will only apply to that Board and its Committees. (Memo dated November 28, 2022)

B. Recommendation as submitted by Laura Guglielmo, Assistant Executive Officer and Roberta Van Nortrick, Acting Division Manager, Administrative Services: That the Board of Retirement review and approve the FY 2022-2023 Mid-Year Budget Amendments for the LACERA Administrative Budget. (Memo dated November 18, 2022)

C. Ratification of Service Retirement and Survivor Benefit Application Approvals. (Memo dated November 29, 2022)

D. Recommendation as submitted by Ricki M. Contreras, Division Manager, Disability Retirement Services: That the Board Dismiss with prejudice Nancy E. Delange's appeal for a service-connected disability retirement. (Memo dated November 22, 2022)

VI. CONSENT ITEMS (Continued)

E. Recommendation as submitted by Ricki M. Contreras, Division Manager, Disability Retirement Services: That the Board grant the appeal and request for administrative hearing received from the following applicant and direct the Disability Retirement Services Manager to refer this case to a referee: Jeffrey R. McKee (Dec'd); Randi McKee (Surviving Spouse). (Memo dated November 21, 2022)

VIII. EXCLUDED FROM CONSENT ITEMS

There were no items excluded from consent items.

IX. NON-CONSENT ITEMS

A. Recommendation as submitted by Carly Ntoya, Ph.D., Human Resources Director: That the Board 1) Approve the proposed classification and compensation changes for implementation for the existing Accounting Officer II, LACERA; Accounting Officer I, LACERA; Senior Accountant, LACERA; Accountant, LACERA; and Accounting Technician I, LACERA, including submission to the Board of Supervisors (BOS); 2) Approve the proposed classification and compensation changes for implementation for the creation of new Senior Investment Accountant, LACERA; Investment Accountant, LACERA; and Accountant II, LACERA classifications, including submission to the Board of Supervisors; and 3) Approve that the Accounting Technician II, LACERA classification be deleted from the Ordinance, including submission to the Board of Supervisors.
(Memo dated November 28, 2022)

Mr. Robbins made a motion, Mr. Pryor seconded, to approve staff's recommendation. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

B. Recommendation as submitted by Santos H. Kreimann, Chief Executive Officer: That the Board review and approve the 2023 meeting calendar and consider rescheduling meeting dates that conflict with a holiday and/or the potential of a lack of quorum. (Memo dated November 28, 2022)

IX. NON-CONSENT ITEMS

Mr. Bernstein made a motion, Mr. Moore seconded, to approve the 2023 meeting schedule for the first Wednesday of each month, except for July and October, which will be held the first Thursday of the month. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Bernstein, and Ms. Gray voting yes; and Mr. Robbins voting no. Ms. Greenwood was absent from the vote.

X. REPORTS

A. Presentation by Anthony Roda, Legislative Advocate, Williams & Jensen and Shane Doucet, Legislative Advocate, Doucet Consulting Solutions regarding the Federal Legislative Update.
(Memo dated November 17, 2022)

Messrs. Roda and Doucet provided a presentation to the Board and answered questions.

B. For Information Only as submitted by Barry w. Law, Legislative Affairs Officer, regarding the 2022 Year-End Legislative Report.
(Memo dated November 23, 2022)

This item was received and filed.

C. For Information Only as submitted by Laura Guglielmo, Assistant Executive Officer, regarding the FY 2021-2022 Final Budget Control Report. (Memo dated November 17, 2022)

This item was received and filed.

D. For Information Only as submitted by Francis J. Boyd, Senior Staff Counsel, regarding the Disability Retirement Application Amendment – Earlier Effective Date. (Memo dated November 28, 2022)

This item was received and filed.

X. REPORTS (Continued)

E. For Information Only as submitted by Santos H. Kreimann, Chief Executive Officer, regarding the Tier I Merit Salary Adjustment and Tier II Step Advancement. (Memo dated November 23, 2022)

This item was received and filed.

F. For Information Only as submitted by Richard P. Bendall, Chief Audit Executive and the Audit Committee, regarding the Los Angeles County's Compliance with Requirements for Rehired Retirees – Fiscal Year Ended June 30, 2021. (Memo dated November 30, 2022)

This item was received and filed.

G. For Information Only as submitted by Ricki M. Contreras, Division Manager, Disability Retirement Services, regarding the Application Processing Time Snapshot Reports.
(Memo dated November 28, 2022)

This item was received and filed.

H. For Information Only as submitted by Ted Granger, Interim Chief Financial Officer, regarding the following reports:

Monthly Trustee Travel & Education Reports for October 2022
(Public memo dated November 21, 2022)
(Confidential memo dated November 21, 2022 – Includes Pending Travel)

Quarterly Trustee Travel & Education Reports – 1st Quarter Fiscal Year 2023
(Public memo dated November 21, 2022

Quarterly Staff Travel Report- 1st Quarter Fiscal Year 2023
(Public memo dated November 21, 2022)

This item was received and filed.

X. REPORTS (Continued)

I. For Information Only as submitted by Steven P. Rice, Chief Counsel, regarding the 2022 Fiduciary Counsel Annual Self-Assessments and DEI Report. (Memo dated November 28, 2022) (Privileged and Confidential Attorney-Client Communication/Attorney Work Product)

This item was received and filed.

J. For Information Only as submitted by Steven P. Rice, Chief Counsel, regarding the November 2022 Fiduciary Counsel Contact and Billing Report. (Memo dated November 28, 2022) (Privileged and Confidential Attorney-Client Communication/Attorney Work Product)

This item was received and filed.

XI. ITEMS FOR STAFF REVIEW

Trustee Robbins requested that staff provide the federal legislative update on a periodic basis instead of annually.

XII. ITEMS FOR FUTURE AGENDAS

There were no Items for Staff Review.

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

XIV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability

APPLICATION NO. & NAME	BOARD ACTION
5275B – JOSLIN FIELDS	Mr. Kehoe made a motion, Ms. Gray seconded, to grant a nonservice-connected disability retirement pursuant to Government Code Sections 31720 and 31724. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez,

XIV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability (Continued)

APPLICATION NO. & NAME	BOARD ACTION
5275B – JOSLIN FIELDS (Continued)	
	Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.
5276B – MIGUEL QUINTERO*	Mr. Knox made a motion, Mr. Moore seconded, to deny a service-connected disability retirement without prejudice. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.
5277B – ADRINA T. MORENO	Mr. Knox made a motion, Mr. Bernstein seconded, to grant a nonservice-connected disability retirement pursuant to Government Code Sections 31720 and 31724. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

*Applicant and Attorney Present

XIV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability (Continued)

APPLICATION NO. & NAME	BOARD ACTION
5278B – AGUSTIN RODRIGUEZ*	Mr. Bernstein made a motion, Mr. Knox seconded, to grant a service-connected disability retirement pursuant to Government Code Sections 31720 and 31724 since employer cannot accommodate. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.
5279B – LARISSA J. YU	Mr. Knox made a motion, Mr. Kehoe seconded, to grant a nonservice-connected disability retirement pursuant to Government Code Sections 31720 and 31724. The makers of the motion amended their motion to include a two-year review. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

*Attorney Present

XIV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability (Continued)

APPLICATION NO. & NAME	BOARD ACTION
5280B – ANGIE RUIZ*	Mr. Moore made a motion, Mr. Kehoe seconded, to refer back to staff for further development. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, and Bernstein voting yes. Ms. Greenwood and Ms. Gray were absent from the vote.
5281B – YESENIA VALDEZ	Mr. Knox made a motion, Mr. Kehoe seconded, to grant a nonservice-connected disability retirement pursuant to Government Code Sections 31720 and 31724. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, and Bernstein voting yes. Ms. Greenwood and Ms. Gray were absent from the vote.
5282B – PATRICIA PLACENCIA	Mr. Moore made a motion, Mr. Bernstein seconded, to deny a service-connected disability retirement. The makers of the motion amended the motion to include without prejudice. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms.

*Applicant Present

XIV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability (Continued)

APPLICATION NO. & NAME	BOARD ACTION
5282B – PATRICIA PLACENCIA (Continued)	
	Greenwood was absent from the vote.
5283B – BERTHENIA REED	Mr. Kehoe made a motion, Mr. Knox seconded, to grant a service-connected disability retirement pursuant to Government Code Sections 31720 and 31724. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.
5235B – ERIC JOHNSON (DEC'D)*	
	Mr. Moore made a motion, Mr. Kehoe seconded, to grant a service-connected disability.
	Mr. Santos made a substitute motion, Mr. Moore seconded, to refer back to staff for further development. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

*Applicant Present

XIV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

B. Disability Retirement Appeals

APPLICATION NO. & NAME	BOARD ACTION
JUDIT HARRIS – Sima G. Aghai Jason E. Waller for the Respondent	Mr. Kehoe made a motion, Mr. Robbins seconded, to deny a service-connected disability retirement and find the applicant not permanently incapacitated. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

C. Staff Recommendations

1. Recommendation as submitted by Ricki M. Contreras, Division Manager, Disability Retirement Services: That the Board approve the service provider invoice for Perry Maloff, M.D.
(Memo dated November 23, 2022)

Mr. Knox made a motion, Ms. Gray seconded, to approve staff's recommendation. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, Bernstein, and Ms. Gray voting yes. Ms. Greenwood was absent from the vote.

2. Recommendation as submitted by Ricki M. Contreras, Division Manager, Disability Retirement Services: That the Board approve the service provider invoice for Stuart Fischer, M.D. c/o Los Alamitos Cardiovascular. (Memo dated November 23, 2022)

XIV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

C. Staff Recommendations (Continued)

Mr. Knox made a motion, Mr. Robbins seconded, to approve staff's recommendation. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Moore, Kehoe, Robbins, and Bernstein voting yes; and Ms. Gray abstaining. Ms. Greenwood was absent from the vote.

XV. EXECUTIVE SESSION

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

1. Administrative Appeal of Cheryl Jackson
(Memo dated November 23, 2022)

The Board met in Executive Session. On a motion by Mr. Kehoe, seconded by Mr. Knox, the Board voted to: deny the appeal of Cheryl Jackson to reissue the pension withdrawal check previously mailed to her. The motion passed (roll call), with Messrs. Bernstein, Kehoe, Knox, Moore, Robbins, Sanchez, and Santos voting yes, and Ms. Gray abstaining. Ms. Greenwood was absent from the vote.

XVI. ADJOURNMENT

There being no further business to come before the Board, the meeting was adjourned at 12:35 p.m.

_____
ALAN BERNSTEIN, SECRETARY

_____
WILLIAM PRYOR, CHAIR

LACERA

December 19, 2022

TO: Each Trustee
Board of Retirement

FROM: Santos H. Kreimann SHK
Chief Executive Officer

FOR: January 4, 2023 Board of Retirement Meeting

SUBJECT: **Board Officers: 2023 Calendar Year**

RECOMMENDATION
That the Board of Retirement ratify its slate of board officers who will serve their term in the 2023 calendar year: Les Robbins as Chair, Alan J. Bernstein as Vice Chair, and Shawn R. Kehoe as Secretary.

LEGAL AUTHORITY
The Board of Retirement (BOR) Regulations provide that each January the BOR shall elect from its members a Chair, Vice Chair, and Secretary to serve for a term of one year or until his or her successor is duly elected and qualified.

The BOR Board Officer Rotation Policy provides that the process of selecting board officers will be a seniority-based system. At the first regular meeting in January, the BOR shall hold a vote to ratify the slate of board officers determined by the Executive Board Assistant.

DISCUSSION
The BOR Board Officer Rotation Policy provides that with reasonable and sufficient time before the first regular meeting in January, the Executive Board Assistant shall verify the seniority of each trustee on the seniority list for each board officer position who would be in office during the calendar year commencing in January and ascertain in order of seniority which trustee opts to serve as a board officer for the upcoming year.

According to the Executive Board Assistant, the following trustees opted to serve as BOR Chair, Vice Chair, and Secretary for the 2023 calendar year.

Chair: Les Robbins
Vice Chair: Alan Bernstein
Secretary: Shawn Kehoe

IT IS THEREFORE RECOMMENDED THAT THE BOARD ratify its slate of board officers as identified above to serve their term in the 2023 calendar year.

Attachment

cc: Board of Investments Luis Lugo JJ Popowich Laura Guglielmo
Steven P. Rice Jon Grabel

BOARD OF RETIREMENT SENIORITY LIST

CHAIR

Trustee Name	Priority Date*	Seniority
Les Robbins	11/1/1997	22 Years, 2 Months
Shawn R. Kehoe	01/01/2011	12 Years
Vivian H. Gray	01/01/2013	10 Years
JP Harris	01/01/2008	7 Years, 3 Months
Herman B. Santos	09/14/2017	5 Years, 3 Months
Keith Knox, Ex-Officio	07/13/2019	3 Years, 5 Months
Alan J. Bernstein	01/01/2022	2 Year
Antonio Sanchez	01/01/22	1 Year
Elizabeth Greenwood	12/01/2022	1 Month
Jason Green	01/01/2023	0 Years
Ronald Okum	01/01/2023	0 Years

VICE CHAIR

Trustee Name	Priority Date*	Seniority
Les Robbins	11/01/1997	22 Years, 2 Months
Alan J. Bernstein	02/01/2011	11 Years, 11 Months
JP Harris	01/01/2008	7 Years, 3 Months
Herman B. Santos	09/14/2017	5 Years, 3 Months
Keith Knox, Ex-Officio	07/13/2019	3 Years, 5 Months
Vivian H. Gray	01/01/2022	2 Year
Antonio Sanchez	01/01/2022	1 Year
Elizabeth Greenwood	12/01/2022	1 Month
Shawn R. Kehoe	01/01/2011	1 Year
Jason Green	01/01/2023	0 Years
Ronald Okum	01/01/2023	0 Years

SECRETARY

Trustee Name	Priority Date*	Seniority
Les Robbins	11/01/1997	22 Years, 2 Months
Shawn R. Kehoe	01/01/2011	12 Years
Vivian H. Gray	01/01/2013	10 Years
JP Harris	01/01/2008	7 Years, 3 Months
Herman B. Santos	09/14/2017	5 Years, 3 Months
Keith Knox, Ex-Officio	07/13/2019	3 Years, 5 Months
Antonio Sanchez	01/01/2022	1 Year
Elizabeth Greenwood	12/01/2022	1 Month
Alan J. Bernstein	02/01/2011	1 Year
Jason Green	01/01/2023	0 Years
Ronald Okum	01/01/2023	0 Years

*Priority Date reflects the first term date of the Trustee on the Board as of January 2023.
2022 Officers have been placed at the end of the list and the priority date reset to one year of service.

LACERA

December 27, 2022

TO: Each Trustee,
Board of Retirement
Board of Investments

FROM: Santos H. Kreimann SHK
Chief Executive Officer

SUBJECT: **CHIEF EXECUTIVE OFFICER'S REPORT – JANUARY 2023**

The following Chief Executive Officer's Report highlights key operational and administrative activities that have taken place during the past month.

Strategic Plan Update

Staff, along with KH Consulting, have been working on finalizing the strategic priorities and objectives. The final draft of the Strategic Plan will then be presented for review by the Trustees as part of the February Board of Retirement (BOR) offsite.

Board of Retirement Offsite

The Board of Retirement Offsite will be held in-person at the end of February 2023. Day one of the offsite will focus on LACERA's strategic planning efforts and gaining Trustee insights and direction. Day two of the offsite will focus on the RHC Program and other educational topics. Details to follow.

Welcome New Board Member

The Board of Supervisors approved Supervisor Barger's appointment of Mr. Okum at its December 20, 2022, meeting. Trustee Okum's term will be effective January 1, 2023 through December 31, 2025.

We are also pleased to officially welcome Trustees Jason E. Green and Elizabeth Greenwood to their first Board of Retirement meeting.

OneMeeting: Board/Committee Agenda Management, Recordings, Online Archives, and Public Interface Update

At its March 2022 Board of Retirement meeting, the Board approved a contract with Prime Government Solutions, Inc. (PrimeGov) now called OneMeeting. This application will be used for both Boards and all Committee meetings, including agenda management, livestreaming, recordings, online archives, and a public interface solution, with an indefinite retention period for archiving the audio and visual recordings. Staff will be going live in January 2023.

OneMeeting: Board/Committee Agenda Management, Recordings, Online Archives, and Public Interface Update (Continued)

Over the last month, both Trustees and staff have been trained on the functionality and use of the new system. In addition to training videos on the new platform, staff will be on hand at the BOR and BOI board meetings to help Trustees with navigating the new platform and to answer any questions you may have. We welcome any feedback from both Trustees and staff as we implement and transition to the OneMeeting platform.

Member Services Call Center

Member Services is pleased to share that our first of two CORE Benefits Training classes officially graduated and have reported to their respective assignments. Nine Specialists have joined the Member Services Call Center and are now taking calls from members, while four Specialists have reported to the Benefits CORE team. Our second CORE Benefits Training class is going through the final stages of training in our Member Services Call Center and will be fully integrated into the Call Center or the Benefits CORE team by mid-January.

The addition of these Specialists will be a big help as we move into the 2022-2023 March Madness season. The Specialists in the first class were already taking calls in the month of November as part of their training and have had a positive impact on our service levels as reflected in the CEO Dashboard report.

This year all of our trainees spent time training in our Call Center. This new addition to our training process helps provide a foundation for the type of highly personalized, accurate and compassionate service that we expect to deliver to our members. Providing a service foundation will help those that move to Benefits to understand the member experience, which will only help as they process member requests in the future.

I would like to take a moment and thank staff members in Quality Assurance, Benefits, Member Services, and Human Resources for their hard work in getting our trainees ready to assist our members. I would also like to thank all the trainees who successfully completed our CORE training program. This is an accomplishment to be proud of and the beginning of their professional growth at LACERA.

As we enter March Madness season, we have a high interest from members for retirement counseling. Twenty-eight percent of all calls in November were for retirement counseling. This is consistent with our October experience. However, while the percentage of calls related to retirement counseling stayed constant, the overall call volume was lower in November (9,501 calls offered) compared to October's volume (13,001 calls offered). This

Member Services Call Center (Continued)

reduction in calls was expected due to new MOUs with salary increases being approved by the County.

Recruitment Updates

Vacancies and Hiring

The investment staff is continuing to review the eligibility lists of prospective candidates for the Senior Investment Officer (Real Estate) and Financial Analyst III (Real Estate) positions.

Also, in collaboration with EFL Associates, LACERA is actively working to secure a pool of qualified and diverse candidates for the Deputy Chief Investment Officer position. The job bulletin has been posted for over a week and EFL is in the process of gathering candidate profiles to build their highly qualified list for interviews.

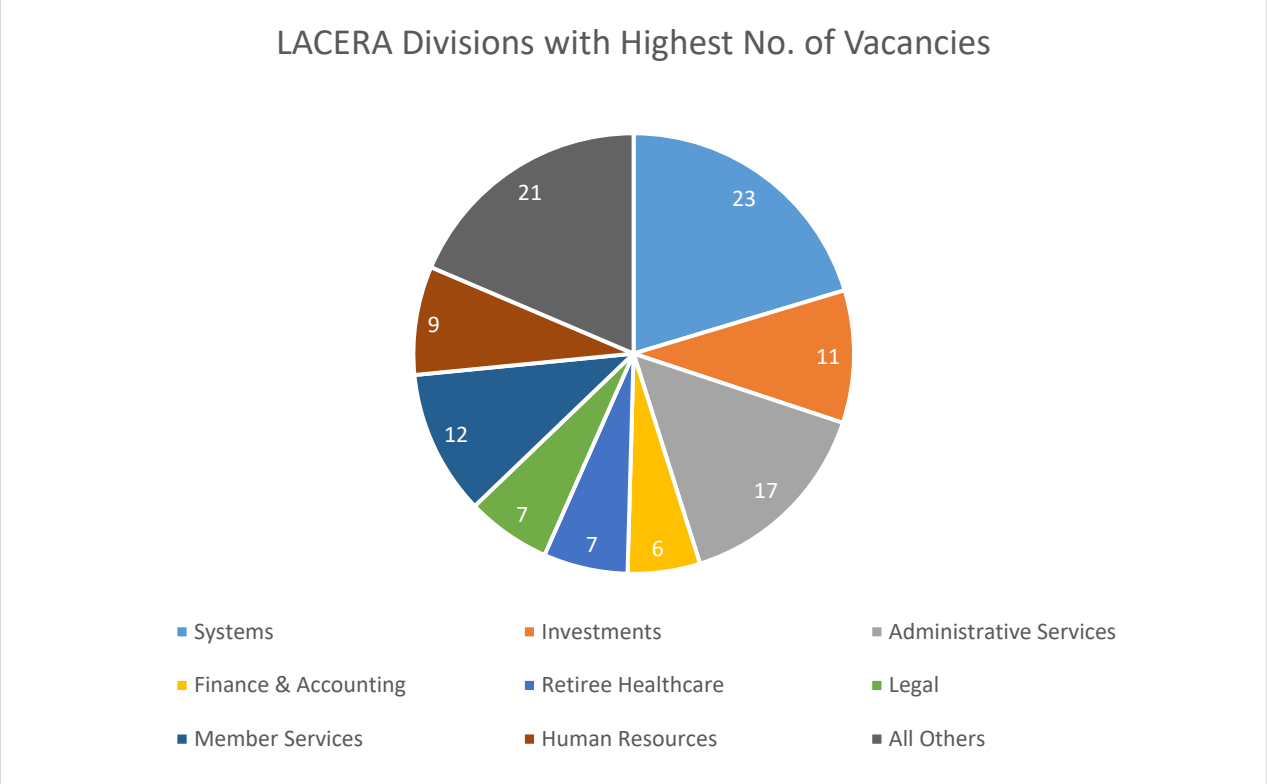
Classification	# of Vacancies	LACERA Priority	Recruitment Stage
Deputy Chief Investment Officer	1	Tier 0	Recruitment Open
Senior Investment Officer (SIO)	1	Tier 0	9 – Division Interviews
Finance Analyst III (FA III)	2	Tier 0	9 – Division Interviews
Finance Analyst II (FA II)	3	Tier 1	Not Started
Principal Investment Officer	1	Tier 2	Not Started
Senior Investment Officer	1	Tier 2	Not Started
Executive Administrative Asst	1	Tier 3	Not Started
Finance Analyst I (FA I)	1	Unassigned	Not Started

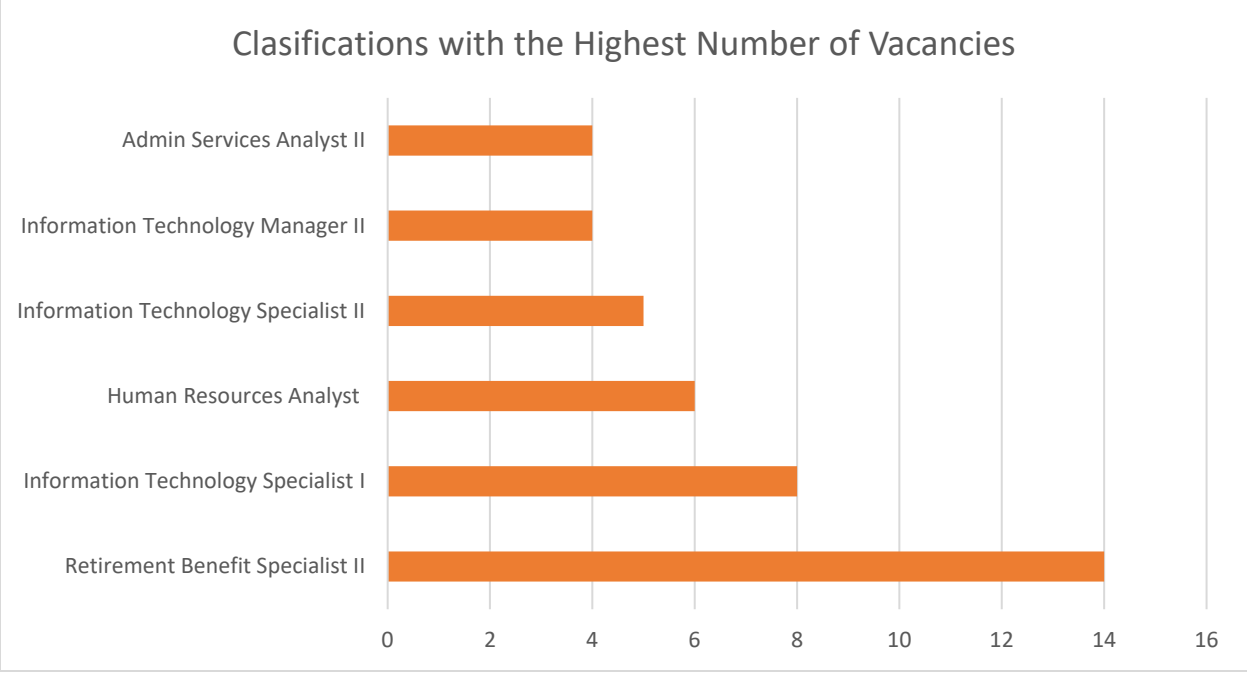
Other External Recruitments

Alliance Resource Consulting has finalized the recruitment brochure for the Chief, Information Technology and Information Security Officer positions and has has begun their recruitment efforts for both positions. The positions are currently open and being broadly advertised, including on LACERA.com.

LACERA has 530 budgeted positions, of which 113 are vacant (21% vacancy rate). The Divisions with the highest number of vacancies, and the classifications with the highest number of vacancies, are shown below.

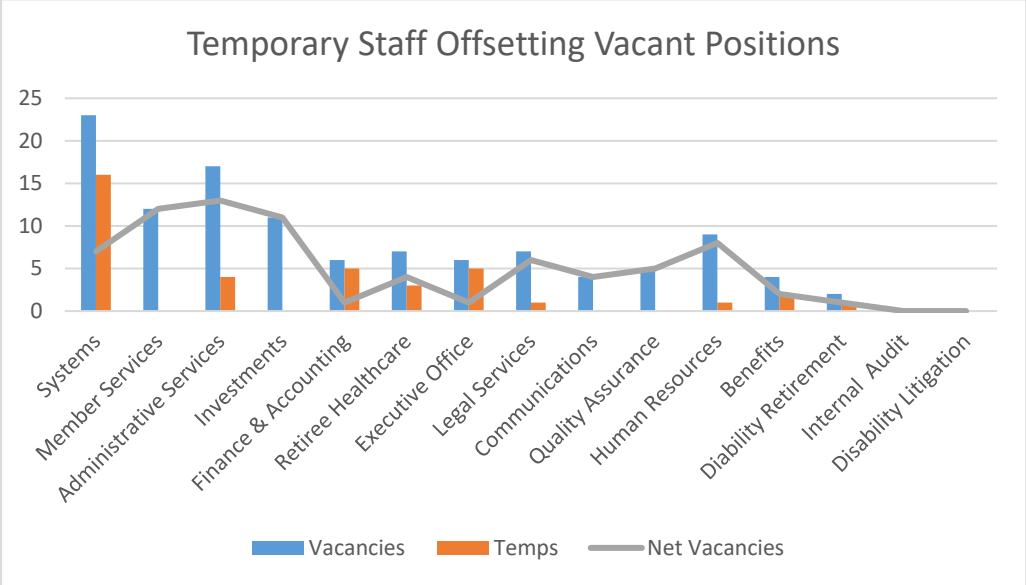
Recruitment Updates (Continued)





The chart below highlights temporary hires across divisions to address critical vacancy needs in the short term.

Recruitment Updates (Continued)



Development

The recruitments/assessments for the following classifications are currently in development in partnership with the various hiring divisions:

- Retirement Systems Specialist
- Division Manager

Recruiting & Assessment

Open recruitment for the following legal positions yielded a limited number of candidates with minimal experience in the public pension field. As such, a request was sent out to engage an outside search firm to help recruit for these specialized positions. Staff members worked with General Counsel to prepare the firm selection criteria and update the job bulletins to be used in our recruitment efforts.

- Senior Staff Counsel (Investments)
- Staff Counsel (Investments)
- Staff Counsel (Benefits)

The examinations for the Human Resources Analyst, Senior Human Resources Analyst, and Senior Human Resources Assistant assessments continue. The Senior Human Resources Assistant written examination is pending. The interviews for the Senior Human Resources Analyst position are scheduled to begin the week of January 9, 2023; invitations are pending. The Human Resources Analyst applications review is nearing completion.

Recruitment Updates (Continued)

New Lists Promulgated

The Eligible Register (List) for Retirement Benefits Specialist I was promulgated and consists of 90 eligible candidates. The List has been provided to the Benefits, Member Services, and Retiree Healthcare Divisions to review and begin their selection process. The Divisions can review the candidate's applications and resumes and conduct a selection interview.

The recruitment for the Financial Analyst III - Corporate Governance position continues. Additional candidates are in the assessment phase and those that pass will be added to the eligibility register (list).

Hiring

We are pleased to announce that during the first half of the fiscal year we have hired 16 new staff members and promoted four staff. Recent and upcoming hiring and selection activities are reflected below as follows:

Classification	# of Positions	Division	Status
Accountant	3	FASD	Started December 1
Accountant	1	RHC	Starting January 3

CEO Dashboard Update

The CEO Dashboard now includes member satisfaction data for both the Member Services Call Center and the Member Service Center virtual and in-person counseling sessions.

Since the beginning of the COVID-19 pandemic and our switch to a cloud-based call center solution, and our overall cloud-based system environment, we have been unable to collect and process member satisfaction survey results. Pre-pandemic our call center survey system was connected to our on-premises call center system, and our Member Service Center survey process was paper-based and reliant on a problematic, end-of-life, survey scanning and processing system. Restoring this functionality has been a key initiative in our overall Member Experience program.

Our Call Center survey system is a modern opt-in survey that asks members four questions about their interaction during the call. The questions are worded to focus the members rating on the specific interaction they just completed. The overall satisfaction question will be the rating that is included in our Key Performance Indicator rating that appears on the Dashboard. The overall satisfaction score is the percentage of respondent

CEO Dashboard Update (Continued)

callers who rated us a 4 or 5 (out of 5) on their responses. The remainder of the survey data will be included in the quarterly updates that are shared with the Operations Oversight Committee.

Our Member Service Center satisfaction survey is part of our new appointment scheduling and queuing program which went live in November. The new appointment scheduling system generates a text message (SMS) survey to every person who completes an in-person or virtual counseling session. Members are presented with four questions (Attached). Respondents can indicate they strongly agree, slightly agree, are neutral, slightly disagree, or strongly disagree to respond to the survey. As with the Call Center, we will be reporting the results of the overall satisfaction question, "I was satisfied with my overall experience with the specialist." In this case, we will use the percentage of respondents who indicate they strongly or slightly agree to determine the number we report on the Dashboard. This number will appear at the top of the Dashboard's first page under the "MSC Overall Satisfaction" box. Also, as with the Call Center, the full rating will be shared in the quarterly Member Service updates to the Operations Oversight Committee.

Retiree Healthcare

Group Contract Termination Update

Last month staff reported that during the week of November 15th, the RHC Call Center had received several calls from LACERA retirees indicating they received notification that their medical group (Providence) was terminating their contract with United Healthcare (UHC) effective January 1, 2023.

The termination of Providence Medical Group would have impacted both active and retired members.

Shortly after placing notice of the planned termination in last month's CEO report, staff received updated notification that UHC and Providence had reached a multi-year agreement that ensured members uninterrupted access to Providence's physicians, facilities and hospitals. Letters were being mailed out by UHC to impacted members informing them of the renewed relationship with Providence and that Providence would be remaining in the UHC network.

SHK
CEO report January 2023.doc

Attachments

MEMBER SERVICE CENTER SATISFACTION SURVEY

Introduction:

We value your feedback and appreciate you taking a few minutes to complete the next four brief questions regarding the service you received today. When answering these questions please consider only the service you received from the last Specialist you spoke with. Your feedback will help us assist you more effectively.

Let's get started. Please provide your response by using your touchtone telephone key pad where "1" is poor and "5" is excellent.

Question 1

How would you rate your satisfaction with the way you were greeted today by the Specialist who assisted you?

Question 2:

How would you rate the Specialist's patience & politeness?

Remember, using your telephone keypad, "1" is poor and "5" is excellent.

Question 3:

How would you rate your satisfaction with the Specialist's knowledge?

Remember, using your telephone keypad, "1" is poor and "5" is excellent.

Question 4:

How would you rate your overall satisfaction with the Specialist handling your call?

Closing:

We appreciate you taking the time to complete our survey. Have a great day

CEO DASHBOARD

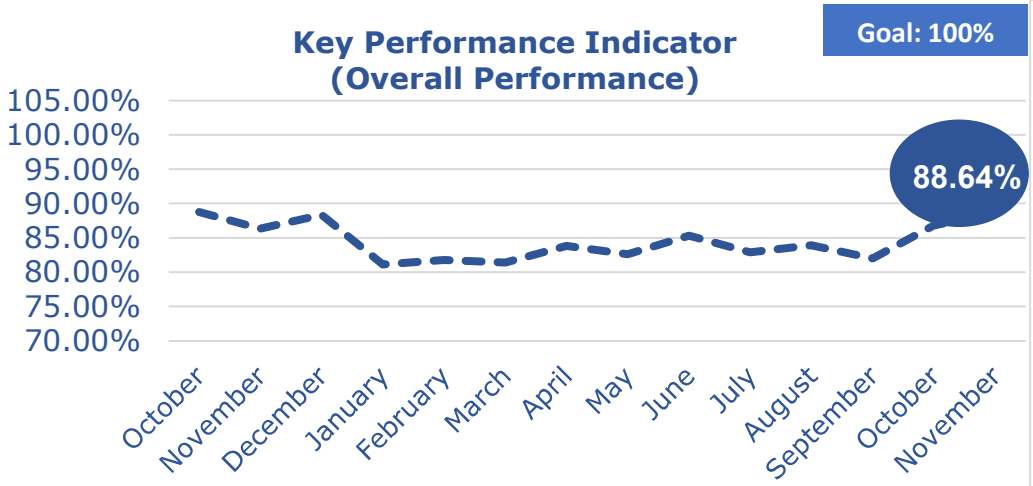
January 4, 2023

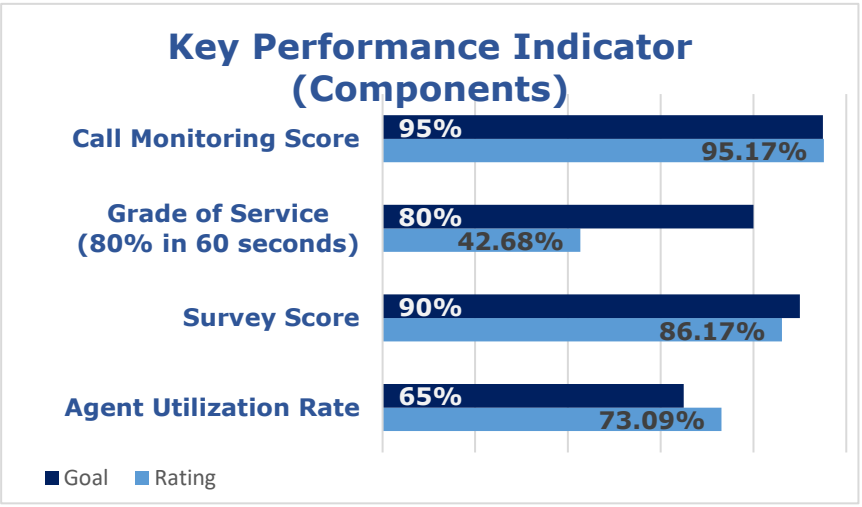
Striving for Excellence

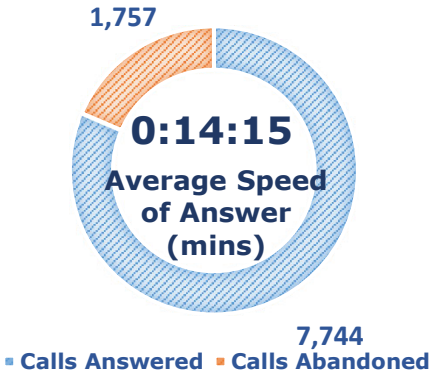
Service Metrics Reported on a Fiscal Year Basis (July 1) Through: November 2022

WORKSHOP ATTENDANCE	OUTREACH EVENTS	WORKSHOP SATISFACTION		MSC OVERALL SATISFACTION		MEMBER SERVICES CALL CENTER
1,108	18	N/A		100.00%		9,501
Year-to-Date: 7,018	Year-to-Date: 100	Resp. Rate	Change	Resp. Rate	Change	3 Month Average 10,438
		0.0%	0	13.4%	0	

Member Services







Top Calls

1. Retirement Counseling: Process Overview
2. Retirement Counseling: Estimate
3. My LACERA: Login-Forgot Password

Emails

476

Avg. Response Time (ART)

24:00 hours

Secure Message

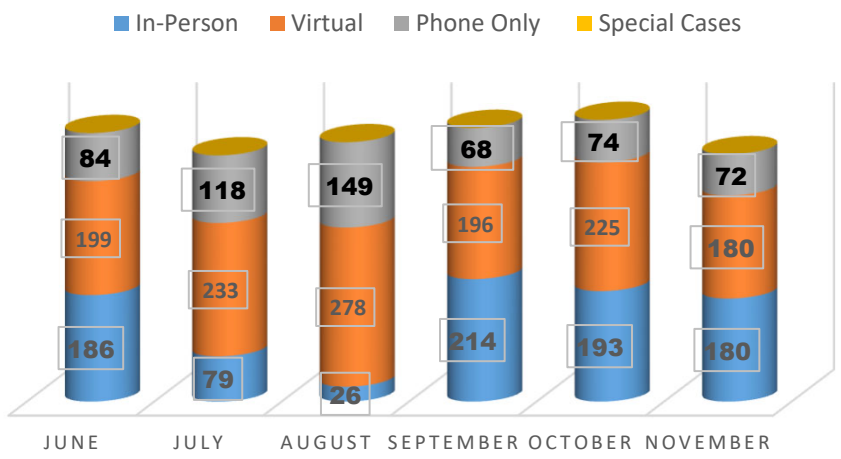
794

Striving for Excellence

Service Metrics Reported on a Fiscal Year Basis (July 1) Through: November 2022

Member Services

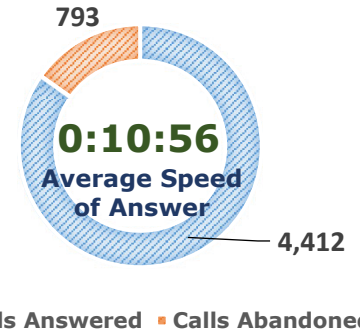
Member Service Center Appointments



COMING SOON

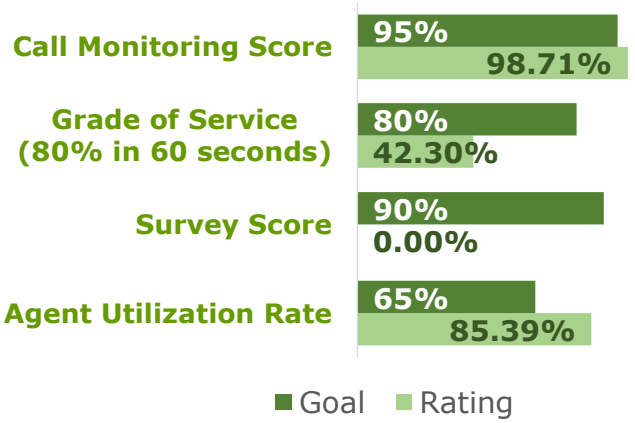
Retiree Healthcare

Total RHC Calls: 5,205



Top Calls

1. Medical/Dental Enrollments
2. Medicare Part B Inquiries
3. General Inquiries



Emails 388

Avg. Response Time (ART) 5 Days

Secure Messages 509

Striving for Excellence

Service Metrics Reported on a Fiscal Year Basis (July 1) Through: November 2022

Disability

Applications 973

In Process As Of 11/30/2022

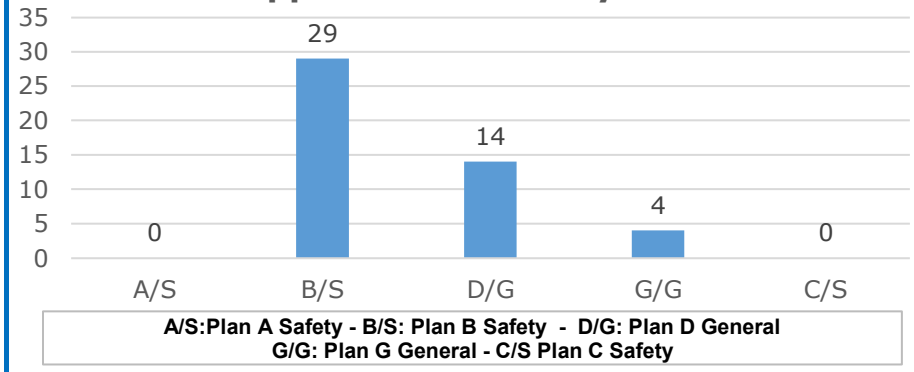
979 Pending on:	10/31/2022
47 Received	
343 Year-to-Date	
0 Re-Opened	
0 Year-to-Date	
53 To Board - Initial	
251 Year-to-Date	
0 Closed	
14 Year-to-Date	

Appeals 73

In Process As Of 11/30/2022

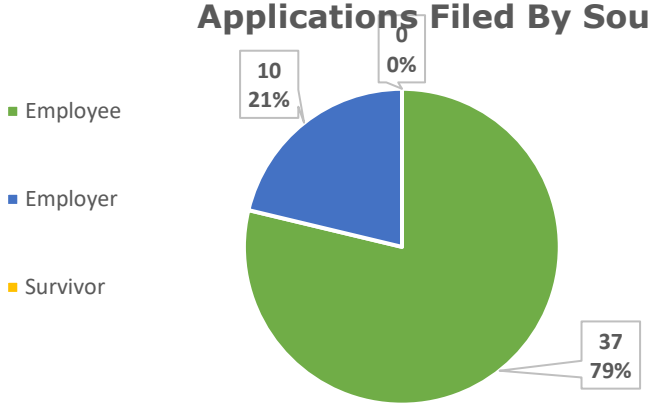
71 Pending on:	10/31/2022
2 Received	
5 Year-to-Date	
0 Admin Closed/Rule 32	
5 Year-to-Date	
0 Referee Recommended	
2 Year-to-Date	
0 Revised/Reconsidered for Granting	
2 Year-to-Date	

Applications Filed By Plan

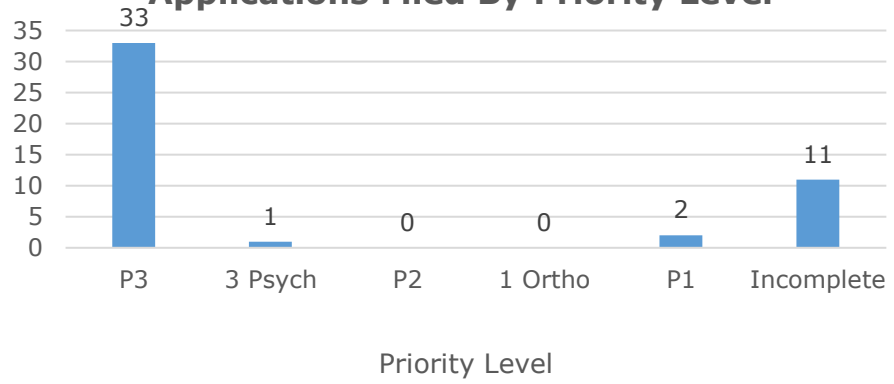


A/S:Plan A Safety - B/S: Plan B Safety - D/G: Plan D General
G/G: Plan G General - C/S Plan C Safety

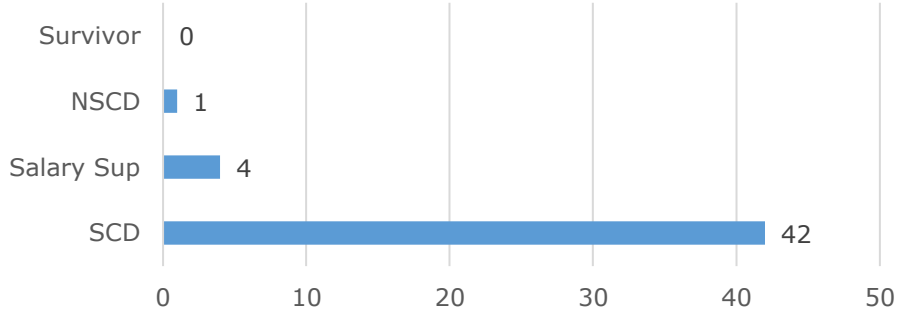
Applications Filed By Source



Applications Filed By Priority Level

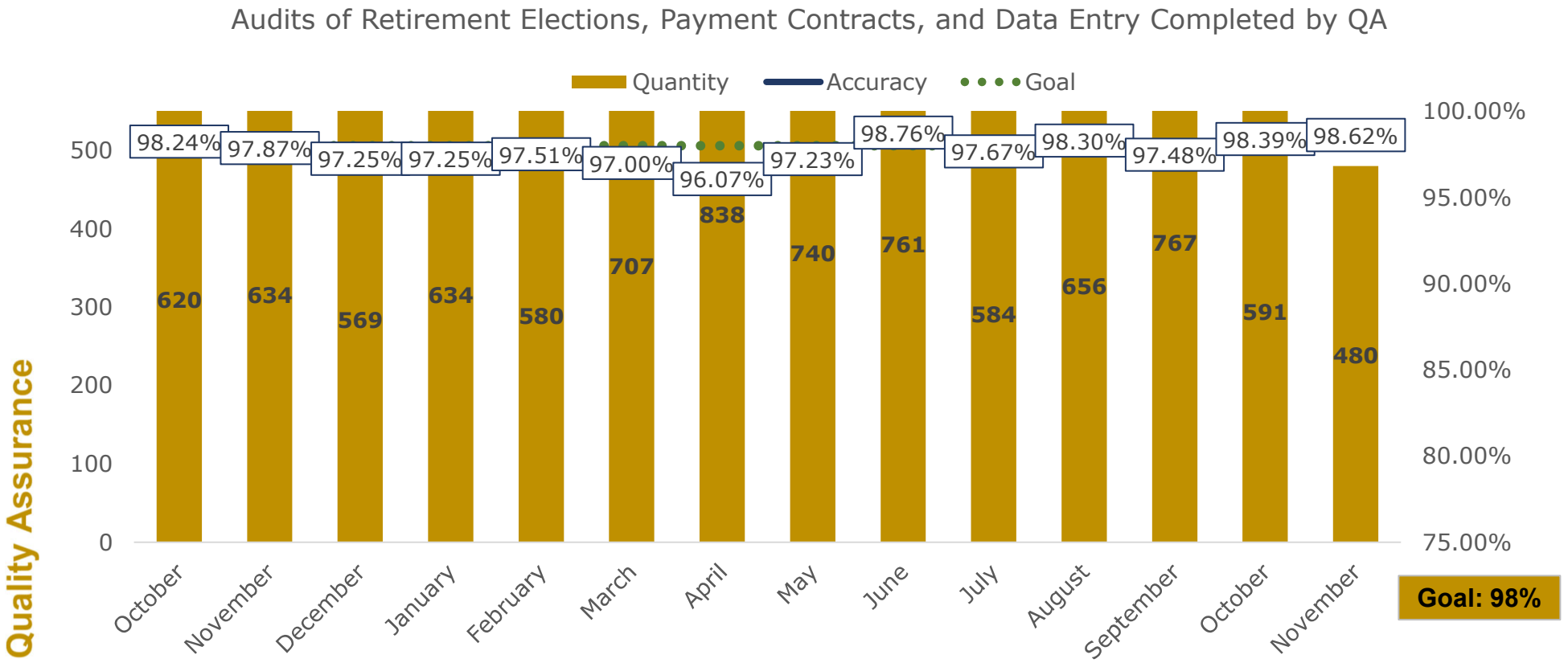


Applications Filed By Type



Striving for Excellence in Quality

Service Metrics Reported on a Fiscal Year Basis (July 1) Through: November 2022



November

98.62%

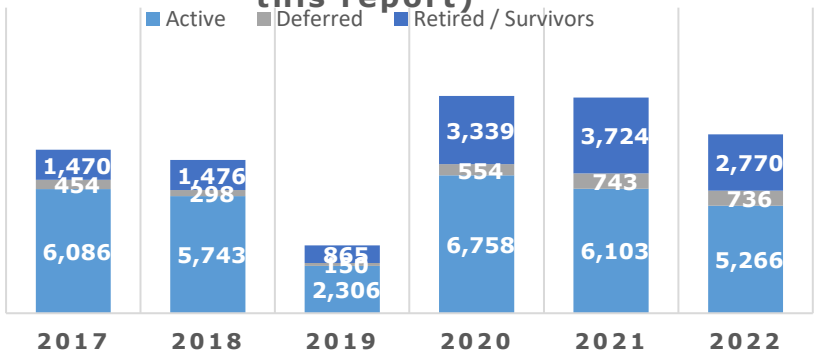
Retirement Elections		Payment Contracts		Data Entry	
230	Samples	160	Samples	90	Samples
99.05%	Accuracy	97.18%	Accuracy	99.63%	Accuracy

Service On-Line for All

Service Metrics Reported on a Fiscal Year Basis (July 1) Through: November 2022

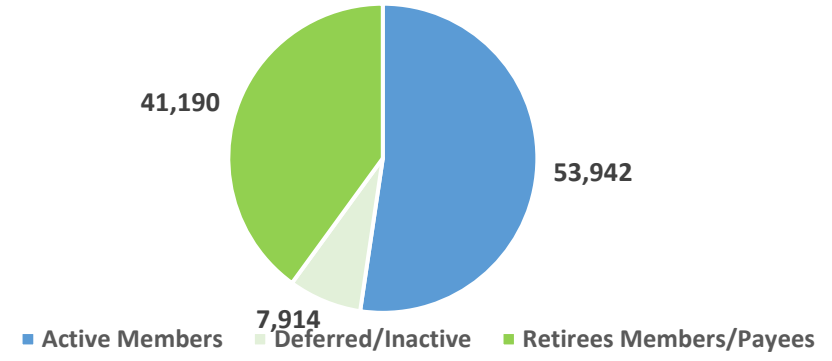
Serving Members Through LACERA.com and MyLACERA

MyLACERA Annual Registration (as of the 15th of the month prior to this report)

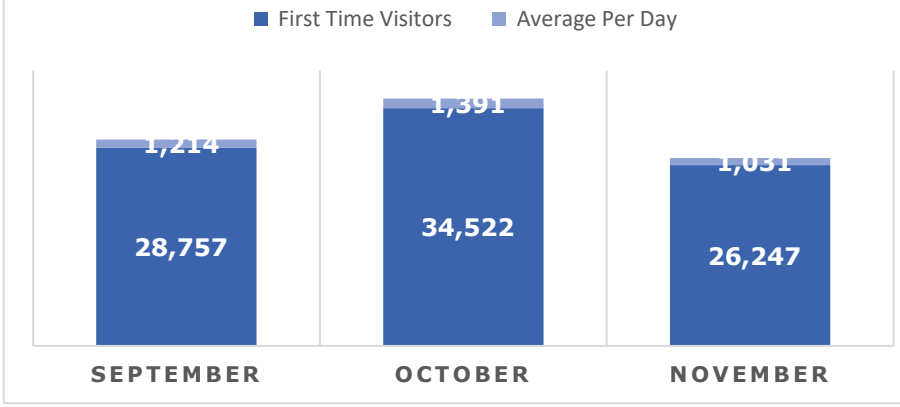


Total Registered Members	103,046	55%

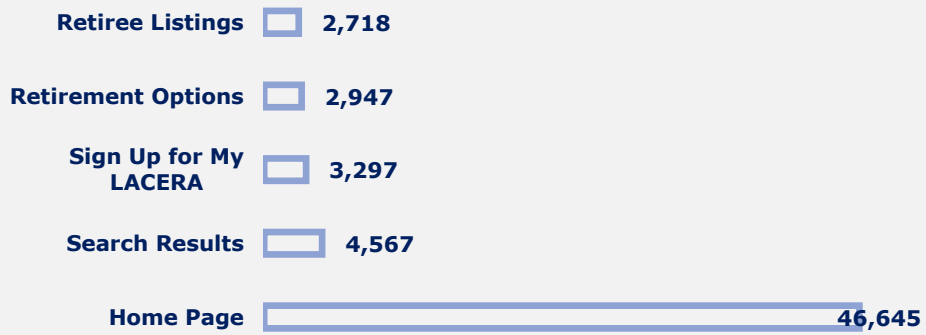
Total Registrations By Member Type



LACERA.com User Traffic



Top Five LACERA.com Page Views



Home Page "I Would Like To" View	Views	% of Change
See my retirement options	3,606	-75%
View Pre-Retirement Workshops	2,287	-22%
Start my retirement planning	2,457	-55%
Add or update my beneficiary	1,180	-31%
View job opportunities	2,340	N/A
Busiest Day of the Month:	**Thursday, 11/28/2022**	

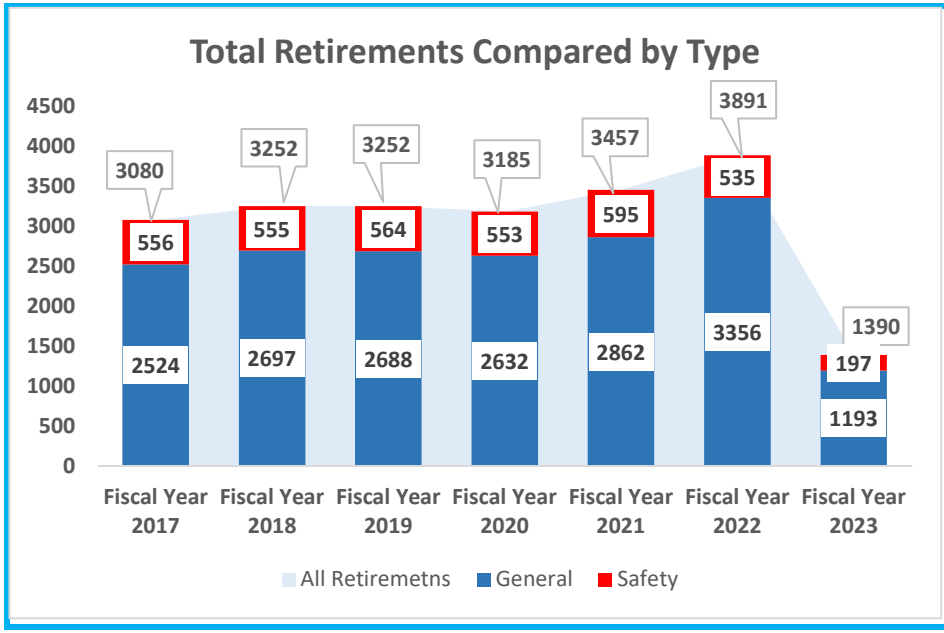
Home Page Tile Views	Views	% of Change
My LACERA	4,669	-43%
Pre-Retirement Workshops	2,287	-22%
Careers	2,098	-55%
Investments	1,561	-34%
Annual Reports	1,093	-39%
Forms and Publications	223	-10%

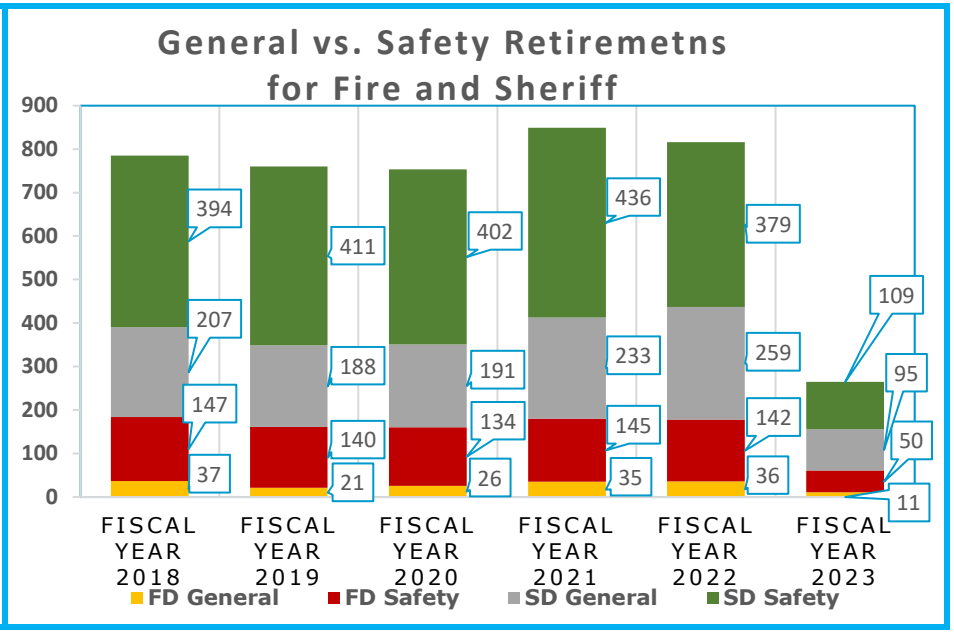
Member Snapshot

Service Metrics Reported on a Fiscal Year Basis (July 1) Through: November 2022

Membership Count as of: 11/15/22

	PLAN	ACTIVE Vested	ACTIVE Non-Vested	INACTIVE Vested	INACTIVE Non-Vested	RETIRED Service	RETIRED SCD - Disability	RETIRED NSCD - Disability	RETIRED Survivors	Totals by Plan/Type
General	PLAN A	55	-	15	32	12,363	1,000	176	4,124	**17,765**
	PLAN B	14	-	5	3	581	44	8	72	**727**
	PLAN C	16	-	5	8	367	40	8	66	**510**
	PLAN D	35,034	141	4,516	3,391	17,946	1,921	440	1,892	**65,281**
	PLAN E	13,587	33	2,965	106	15,052	-	-	1,569	**33,312**
	PLAN G	16,714	17,920	1,371	6,080	199	23	4	18	**42,329**
	TOTAL GENERAL	**65,420**	**18,094**	**8,877**	**9,620**	**46,508**	**3,028**	**636**	**7,741**	**159,924**
Safety	PLAN A	1	-	2	2	1,883	2,497	27	1,653	**6,065**
	PLAN B	7,848	91	582	233	3,245	4,272	56	392	**16,719**
	PLAN C	2,201	2,599	110	457	11	13	-	2	**5,393**
	TOTAL SAFETY	**10,050**	**2,690**	**694**	**692**	**5,139**	**6,782**	**83**	**2,047**	**28,177**
	TOTAL ALL TYPES	**75,470**	**20,784**	**9,571**	**10,312**	**51,647**	**9,810**	**719**	**9,788**	**188,101**





Member Snapshot

Average Monthly Benefit Allowance Distribution 12/22/2022	General	Safety	Total	%
$0 to $3,999	30,207	1,500	31,707	51.0%
$4,000 to $7,999	14,238	3,452	17,690	28.5%
$8,000 to $11,999	4,050	4,282	8,332	13.4%
$12,000 to $15,999	1,121	2,136	3,257	5.2%
$16,000 to $19,999	371	439	810	1.3%
$20,000 to $23,999	111	139	250	0.4%
$24,000 to $27,999	30	40	70	0.1%
> $28,000	23	5	28	0.0%
Totals	50,151	11,993	62,144	100%

Average Monthly Benefit Amount: $ 4,708.00

Healthcare Program
(Mo. Ending:11/30/2022)

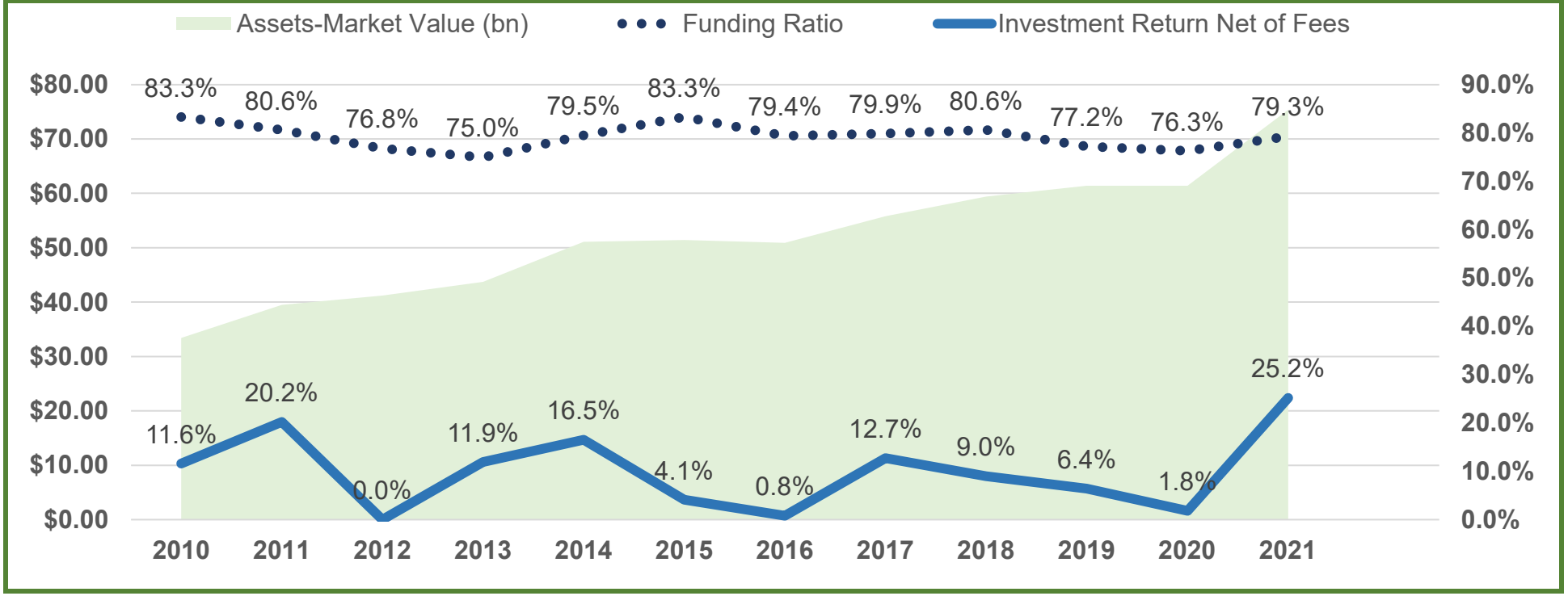
	Employer	Member
Medical	$250.0	$18.2
Dental	$19.7	$1.9
Part B	$39.1	$0.0
Total	**$308.8**	**$20.1**

Health Care Enrollments
(Mo. Ending:11/30/2022)

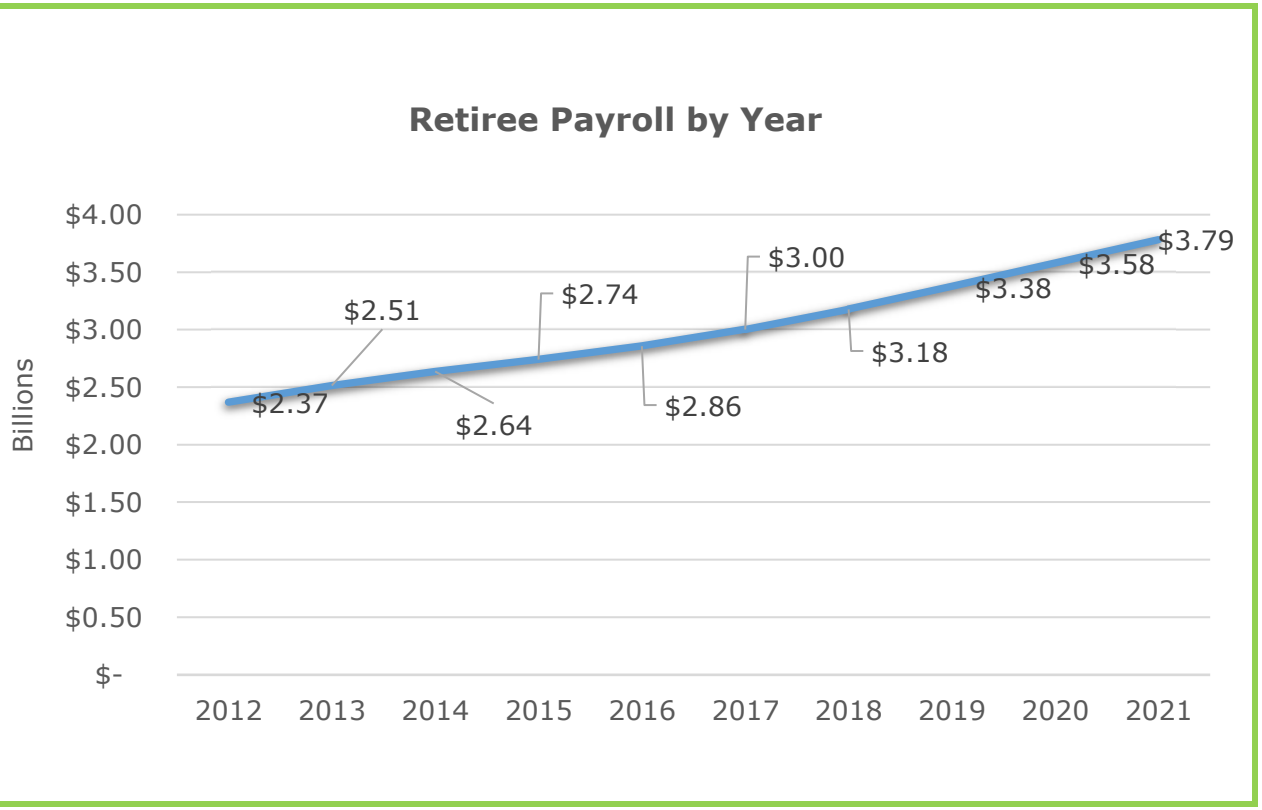
Medical	54,578
Dental	56,352
Part B	37,483
LTC	517
Total	**148,930**

KEY FINANCIAL METRICS

Fiscal Year End Financial Update (as of 06/30/2021)



Key Financial Metrics



FUNDING METRICS (as of 6/30/21)

Employer NC	10.88%
UAAL	13.58%
Assumed Rate	7.00%
Star Reserve	$614m
Total Assets	$73.0b

Contirbutions (as of 6/30/21)

	Employer	Member
Annual Add	$2.0b	$761.0m
% of Payroll	24.46%	7.87%

Contirbutions (as of 6/30/21)

(Net of Fees)

5 YR: 10.8% **10 YR:** 8.6%

Retired Members Payroll

(As of 11/30/2022)

Monthly Payroll	$352.08m
Payroll YTD	$1.8b
New Retired Payees Added	290
Seamless %	97.24%
New Seamless Payees Added	1,499
Seamless YTD	95.60%
By Check %	2.00%
By Direct Deposit %	98.00%

LACERA

QUIET PERIOD LIST
Last Update 12/30/2022

ADMINISTRATIVE/OPERATIONS

RFP/RFQ/RFI Name	Issuing Division	Date Issued	Status*	Quiet Period for Respondents*
Search for Classification & Compensation Study Services (HR)	Human Resources	5/24/2021	Bid Review	• Koff and Associates • Magnova Consultant • Grant Thornton • Reward Strategy Group
Search for Classification & Compensation Study Services (RHC)	Human Resources	5/24/2021	Bid Review	• Koff and Associates • Magnova Consultant • Grant Thornton • Reward Strategy Group
Investments Operational Due Diligence	Internal Audit	5/20/2022	Contract Development	• KPMG
External Financial Auditor	Internal Audit	11/03/2022	Solicitation Process	• Plante Moran • Clifton Larson Allen • BDO • RSM-McGladrey • Moss Adams
Prepaid Debit Card Services	Benefits	6/15/2022 Posted on ISD's solicitation website August 2022	Bid review	• US Bank • Conduent
Business Continuity Professional Services	Administrative Services	8/17/2022	Selection Process	• BDO • BDA Global • Riskonnect • MHA Consulting • Treuvizion Consulting Corp.

RFP/RFQ/RFI Name	Issuing Division	Date Issued	Status*	Quiet Period for Respondents*
Federal Legislative Advocacy Services	Legal Division	11/09/2022	Solicitation Process	• Williams & Jensen / Doucet Consulting Solutions
State Legislative Advocacy Services	Legal Division	11/09/2022	Solicitation Process	• McHugh Koepke & Associates
Securities Litigation Monitoring and Approved Counsel	Legal Division	11/14/2022	Selection Process	• Kirby McInerny • Grant & Eisenhofer • Quinn Emanuel • Labaton • Barack Rodos • Bleichmar Fonti Auld • Bernstein, Litowitz, Berger & Grossmann • Berman Tabacco • Dividex • Cohen Milstein • Kessler Topaz • Rosen • Kaplan Fox • Lieff Cabraser • Motley Rice • Pomerantz • Robbins Geller Rudman & Dowd • Saxena White

*Subject to change

INVESTMENTS QUIET PERIOD FOR SEARCH RESPONDENTS

None at this time

Date	Conference
January, 2023	
22-24	NCPERS (National Conference on Public Employee Retirement Systems) Legislative Conference Washington, D.C.
30-February 1	IFEBP (International Foundation of Employment Benefit Plans) Health Benefits Conference Clearwater Beach, FL
February, 2023	
26-28	RFK Compass Investors Program Miami, FL
March, 2023	
1-3	Pacific Pension Institute (PPI) Winter Roundtable La Jolla, CA
4-7	CALAPRS (California Association of Public Retirement Systems) General Assembly Meeting Monterey, CA
6-8	Council of Institutional Investors (CII) Spring Conference Washington D.C.
14-16	AHIP (America's Health Policy and Markets Forum Washington D.C.
20-23	2023 Infrastructure Investor Global Summit Berlin, Germany
22-23	PREA (Pension Real Estate Association) Spring Conference Seattle, WA
29-31	CALAPRS (California Association of Public Retirement Systems) Advanced Principles of Pension Governance for Trustees at UCLA Los Angeles, CA
April, 2023	
17-21	Investment Strategies & Portfolio Management Wharton School, University of Pennsylvania
23-26	CRCEA (California Retired County Employees Association) Spring Conference Ontario, CA
24-25	IFEBP (International Foundation of Employment Benefit Plans) Health Care Mgmt. Conference Miami, FL
24-25	IFEBP (International Foundation of Employment Benefit Plans) Investments Institute New Orleans, LA

Date	Conference
30-May 3	Milken Institute Global Conference Los Angeles, CA
May, 2023	
9-12	SACRS Spring Conference San Diego, CA
20-21	NCPERS (National Conference on Public Employee Retirement Systems) Trustee Educational Seminar (TEDS) New Orleans, LA
20-21	NCPERS (National Conference on Public Employee Retirement Systems) Accredited Fiduciary (NAF) Program New Orleans, LA
21-24	NCPERS (National Conference on Public Employee Retirement Systems) Annual Conference & Exhibition (ACE) New Orleans, LA
21-24	Government Finance Officers Association (GFOA) Annual Conference Portland, OR
22-23	IFEBP (International Foundation of Employment Benefit Plans) Washington Legislative Update Washington D.C.
June, 2023	
13-15	AHIP (America's Health Insurance Plans) 2023 Portland, OR
July, 2023	
19-21	Pacific Pension Institute (PPI) Summer Roundtable San Francisco, CA
September, 2023	
11-13	Council of Institutional Investors (CII) Fall Conference Long Beach, CA
October, 2023	
1-4	IFEBP (International Foundation of Employment Benefit Plans) Annual Employee Benefits Conference Boston, MA
8-11	National Association of Corporate Directors (NACD) Summit 2023 Fort Washington, MD
18-20	PREA (Pension Real Estate Association) Annual Institutional Investor Conference Boston, MA

Date	Conference
22-25	NCPERS (National Conference on Public Employee Retirement Systems) FALL (Financial, Actuarial, Legislative & Legal) Conference Las Vegas, NV
25-27	Pacific Pension Institute (PPI) Asia Roundtable Tokyo, Japan
November, 2023	
7-10	SACRS Fall Conference Rancho Mirage, CA

DISABILITY RETIREMENT APPLICATIONS
FOR MEETING OF JANUARY 4, 2023

CONSENT CALENDAR: **SAFETY - SCD**
(1D - 999D) **Law Enforcement, Sheriff's, D.A. Investigators**

ATTY	APPLICATION NUMBER	LR	NAME	DEPT. NO.	REQ.	RECOMMENDATION		BOARD ACTION	INV
						PHYS.	STAFF		
YERITSYAN	861D		PARINO, MYRNA J.	SH	SCD	SCD	SCD		NA
WICKE	862D		DIVIAK, DAREN J.	SH	SCD	SCD	SCD EMPLOYER CANNOT ACCOMMO-DATE		NA
WICKE	863D		ALTAMIRANO, VANESSA M.	SH	SCD	SCD	SCD		SR
WICKE	864D		HILL, CHRISTOPHER A.	SH	SCD	SCD	SCD		JS
WICKE	865D		MOLNER, BRADD A.	SH	SCD	SCD	SCD EMPLOYER CANNOT ACCOMMO-DATE		AVG
AGATSTEIN	866D		ULLOA, JOEL A.	SH	SCD	SCD	SCD		RB
YERITSYAN	867D		GUBRAN, JACOB S.	SH	SCD	SCD	SCD		MLY
WICKE	868D		MAYBURY, ROBERT G., JR.	SH	SCD	SCD	SCD		RB
NONE	869D		QUINTANA, MARCO T.	SH	SCD	SCD	SCD		MLY
WICKE	870D		AYALA, ALEXANDER O.	SH	SCD	SCD	SCD		AK
TREGER	871D		GORDON, JOEL A.	SH	SCD	SCD	SCD		PS
YERITSYAN	872D		MELVILLE, JONATHAN L.	SH	SCD	SCD	SCD		MS
WICKE	873D		HATHAWAY, CRAIG A.	SH	SCD	SCD	SCD		PS
WICKE	874D		VERDIN, FERNANDO A.	SH	SCD	SCD	SCD		RB
NONE	875D		TOYOS, ALEXANDER .	SH	SCD	SCD	SCD		DH

LR * Legal Recommendation

DISABILITY RETIREMENT APPLICATIONS
FOR MEETING OF JANUARY 4, 2023

CONSENT CALENDAR: **SAFETY - SCD - CONTINUED**
(1D - 999D) **Law Enforcement, Sheriff's, D.A. Investigators**

ATTY	APPLICATION NUMBER	LR	NAME	DEPT. NO.	REQ.	RECOMMENDATION		BOARD ACTION	INV
						PHYS.	STAFF		
TREGER	876D		GELLIS, BRIAN D.	SH	SCD	SCD	SCD		MS
WICKE	877D		HENNESSY, SCOTT S.	SH	SCD	SCD	SCD		RML
TREGER	878D		MALDONADO, LINDA .	SH	SCD	SCD	SCD		SF
TREGER	879D		RANES, MICHAEL L.	SH	SCD	SCD	SCD RETRO		RM
YERITSYAN	880D		TILLMAN, FAYON D.	SH	SCD	SCD	SCD		ML
WICKE	881D		ALLEN, MECHAELLE-ANN O.	SH	SCD	SCD	SCD		MSM
OZERAN	882D		DOWLING, CASEY C.	SH	SCD	SCD	SCD		AK
WICKE	883D	*	BLACK, DINA M.	SH	SCD	SCD	SCD		PS
WICKE	884D		ROBINSON, ERIKA	SH	SCD	SCD	SCD RETRO		ML
TREGER	885D		SOTO, RICHARD J.	SH	SCD	SCD	SCD RETRO		MS
TREGER	886D		ELDRIDGE, WILLIAM T.	SH	SCD	SCD	SCD		ABD
YERITSYAN	887D		LANG, MICHAEL B.	SH	SCD	SCD	SCD		MG
NONE	888D		CHEVALIER, IRMA T.	SH	SCD	SCD	SCD EMPLOYER CANNOT ACCOMMO-DATE		ABD
TREGER	889D		SHERMAN, SHELDON D.	SH	SCD	SCD	SCD EMPLOYER CANNOT ACCOMMO-DATE		AVG

LR * Legal Recommendation

DISABILITY RETIREMENT APPLICATIONS
FOR MEETING OF JANUARY 4, 2023

CONSENT CALENDAR: **SAFETY - SCD**
(1000B - 1999B) **Fire, Lifeguards**

ATTY	APPLICATION NUMBER	LR	NAME	DEPT. NO.	REQ.	RECOMMENDATION		BOARD ACTION	INV
						PHYS.	STAFF		
WICKE	1552B		REINEMAN, MICHAEL R.	FR	SCD	SCD	SCD		NA
TREGER	1553B		TOVAR, JOSE A.	FR	SCD	SCD	SCD		RML
TREGER	1554B		BURNLEY, TERRY R.	FR	SCD	SCD	SCD		RML
TREGER	1555B		SCANLAN, DAVID E.	FR	SCD	SCD	SCD		RM
TREGER	1556B		MANCHA, JOHN G.	FR	SCD	SCD	SCD		DH
TREGER	1557B		DOUTY, DEAN G.	FR	SCD	SCD	SCD		AK
TREGER	1558B		LYON, GUSTAF S.	FR	SCD	SCD	SCD		RB
TREGER	1559B		RODRIGUEZ, ROBERT J.	FR	SCD	SCD	SCD		SF
TREGER	1560B		RUSSELL, BEN J.	FR	SCD	SCD	SCD		AK
TREGER	1561B		OVERSTREET, ROBERT C.	FR	SCD	SCD	SCD		NA
TREGER	1562B		CHING, JAKE P.	FR	SCD	SCD	SCD		MSC
TREGER	1563B		APODACA, ROBERT A.	FR	SCD	SCD	SCD		MSC
TREGER	1564B		SCANLON, PATRICK K.	FR	SCD	SCD	SCD		PS
TREGER	1565B		LARSON, JOHN	FR	SCD	SCD	SCD RETRO		SF

LR * Legal Recommendation

DISABILITY RETIREMENT APPLICATIONS
FOR MEETING OF JANUARY 4, 2023

CONSENT CALENDAR: **GENERAL MEMBERS - SCD**
(2000C - 2999C)

ATTY	APPLICATION NUMBER	LR	NAME	DEPT. NO.	REQ.	RECOMMENDATION		BOARD ACTION	INV
						PHYS.	STAFF		
NONE	2482C		STROHMEIER, CHRISTIAN F.	SS	SCD	SCD	SCD RETRO EMPLOYER CANNOT ACCOMMO-DATE		MG
NONE	2483C		BAKER, ROBERT L., JR.	PB	SCD	SCD	SCD		MSM
NONE	2484C		PATEL, HEMA	PB	SCD	SCD	SCD EMPLOYER CANNOT ACCOMMO-DATE		MG
POLHAMUS	2485C		MOORE, DEBRA J.	PH	SCD	SCD	SCD RETRO EMPLOYER CANNOT ACCOMMO-DATE		NA
NONE	2486C		JIMENEZ, WANDA	PB	SCD	SCD	SCD		NA
NONE	2487C		BYRD, LORRI A.	SS	SCD	SCD	SCD RETRO		KDH
NONE	2488C		CLARK, SHINMEKA M.	PB	SCD	SCD	SCD SALARY SUPPLEMENT		JS

LR * Legal Recommendation

DISABILITY RETIREMENT APPLICATIONS
FOR MEETING OF JANUARY 4, 2023

CONSENT CALENDAR: **GENERAL MEMBERS - NSCD**
(4000 - 4999)

ATTY	APPLICATION NUMBER	LR	NAME	DEPT. NO.	REQ.	RECOMMENDATION		BOARD ACTION	INV
						PHYS.	STAFF		
NONE	4416		KLAPP, XIOMARA A.	AS	NSCD	NSCD	NSCD		KDH
NONE	4417		VALDEZ, ELIZABETH M.	PB	NSCD	NSCD	NSCD		MSM

LR * Legal Recommendation

LACERA

December 21, 2022

TO: Each Trustee,
Board of Retirement
Board of Investments

FROM: Steven P. Rice, SPR
Chief Counsel

FOR: January 4, 2023 Board of Retirement Meeting
January 11, 2023 Board of Investments Meeting

SUBJECT: Approval of the Use of Teleconference Meeting Technology Under AB 361 and Government Code Section 54953(e), including as Part of Hybrid Board and Committee Meetings

RECOMMENDATION

That, under AB 361 and Government Code Section 54953(e)(3) of the Brown Act, the Board of Retirement and Board of Investments separately consider whether to find that the Governor's COVID-19 State of Emergency continues to directly impact the ability of each Board and its Committees to meet safely in person and that other public agencies still recommend social distancing such that each Board and its Committees shall hold teleconference meetings for the next 30 days as part of hybrid meetings also in person, so long as the State of Emergency remains in effect, and direct staff to comply with the agenda and public comment requirements of Section 54953(e)(3). Action taken by each Board will only apply to that Board and its Committees.

Pursuant to the action of both Boards at the joint meeting on September 23, 2022, starting with the November 2022 Board and Committee meetings, teleconference meetings, if approved, will be agendized as hybrid meetings where trustees may attend by teleconference or in person in the boardroom at LACERA's offices at 300 N. Lake Avenue, Pasadena, California 91101, with adequate provision being made for public comment via teleconference, in person, and in writing and for public attendance via teleconference and in person.

LEGAL AUTHORITY

Under Article XVI, Section 17 of the California Constitution, the Boards have plenary authority and exclusive fiduciary responsibility for the fund's administration and investments. This authority includes the ability of each Board to manage their own Board and Committee meetings and evaluate legal options for such meetings, such as whether to invoke teleconferencing of meetings under AB 361 and Government Code Section 54953(e) of the Brown Act to protect the health and safety of Trustees, staff, and the

public. The Boards previously took this action at their meetings since October 2021. Findings made under this memo will be effective for meetings during the next 30 days, so long as the State of Emergency remains in effect.

DISCUSSION

A. Summary of Law.

On September 16, 2021, the Governor signed AB 361 which enacted new Government Code Section 54953(e) of the Brown Act to put in place, effective immediately and through December 31, 2023, new teleconferencing rules that may be invoked by local legislative bodies, such as the LACERA Boards, upon making certain findings and following certain agenda and public comment requirements.

Specifically, Section 54953(e)(3) provides that the Boards may hold teleconference meetings without the need to comply with the more stringent procedural requirements of Section 54953(b)(3) if a state of emergency under Section 8625 of the California Emergency Services Act impacts the safety of in person meetings or state or local officials have imposed or recommended social distancing rules, provided that the Board makes the following findings by majority vote:

(A) The Board has considered the circumstances of the state of emergency; and

(B) Any of the following circumstances exist:

- (i) The state of emergency continues to directly impact the ability of the Trustees to meet safely in person; or
- (ii) State or local officials continue to impose or recommend measures to promote social distancing.

If each Board makes the required findings, that Board and its Committees may hold teleconference meetings for the next 30 days without the need to comply with the regular rules of Section 54953(b)(3) provided that: agendas are prepared and posted under the Brown Act; members of the public are allowed to access the meeting via a call-in option or an internet-based service option; and the agenda provides an opportunity for public comment in real time and provides notice of the means of accessing the meeting for public comment. Upon making the required findings, the Boards have discretion to hold meetings either entirely by teleconference or as hybrid meetings with individual trustees and the public able to attend either by teleconference or in person.

These emergency rules under Section 54953(e) remain in effect under AB 2449, which becomes law on January 1, 2023 and create additional new grounds for teleconference attendance at Board and Committee meetings. AB 2449 is discussed separately on the agenda for this meeting.

B. Information Supporting the Required Findings and Process if the Boards Determine to Invoke Section 54953(e).

The Governor's State of Emergency for the COVID-19 pandemic as declared in the Proclamation of a State of Emergency dated March 4, 2020 remains active. The Proclamation was issued under the authority of Section 8625 of the California Emergency Services Act. Over the past year, the Governor actively terminated many emergency provisions. *See, e.g.,* Order No. N-21-21, issued November 10, 2021, Order No. N-04-22, issued February 25, 2022. Very recently, the Governor terminated additional COVID provisions. *See* Order No. N-11-22, issued June 17, 2022. In the press release for the June 17 Order, the Governor's Office stated that, after June 30, 2022, "only 5 percent of the COVID-19 related executive order provisions issued throughout the pandemic will remain in place."

On October 17, 2022, the Governor announced that the COVID State of Emergency will end on February 28, 2023. However, the State of Emergency remains in effect until then. The Governor's press release stated that one of the purposes of deferring the end of pandemic until 2023 was to "provid[e] state and local partners the time needed to prepare for this phaseout and set themselves up for success afterwards." Among the transition items reasonably interpreted as included for local agencies such as LACERA is a phaseout of teleconference meetings.

The Los Angeles County Department of Public Health still maintains guidance "That there are certain places where COVID-19 spreads more easily: ● Closed spaces with poor air flow. ● Crowded places with many people nearby. ● Close contact settings especially where people are talking (or breathing heavily) close together." http://publichealth.lacounty.gov/acd/ncorona2019/reducingrisk/. The County Public Health Department also maintains guidance for employers: "Reduce indoor crowding. A few example strategies to decrease crowding include, but are not limited to: ● Host larger meetings outdoors or virtually. ● Reduce occupancy and spread-out seating in meeting rooms and other small spaces such as locker rooms, weight rooms, restrooms, and saunas. Ensure good ventilation . . . . ● Establish procedures to prevent crowding among persons waiting to enter or exit a large event. Limiting attendance, establishing unidirectional foot traffic patterns, reservations, online waiting lists, timed entry or exit, and using staff to help direct traffic and limit access if the area becomes too crowded can help. " http://publichealth.lacounty.gov/acd/ncorona2019/BestPractices/.

Despite this County Health Department guidance, the Board of Supervisors recently resumed in person meetings on September 27, 2022. However, on December 6 and 20, 2022, the Board of Supervisors again approved AB 361 findings to permit teleconference meetings. For in person meetings, the County provides enhanced air filtration, limits

attendance, and provides a designated media area. All persons in attendance must be masked. Telephonic public comment and livestreaming are still be provided. The LACERA Boards are not required to follow the Board of Supervisors' decision with regard to how meetings are conducted, but the County's change in practices is instructive.

The City of Pasadena (City), where LACERA's offices are located and Board and Committee meetings are held, has substantially revised its guidance to give more flexibility. The City still offers guidance that businesses recognize that COVID-19 continues to pose a risk to communities, and it is important for employers to continue to take steps to reduce the risk of COVID-19 transmission among their workers and visitors. https://www.cityofpasadena.net/economicdevelopment/covid-19-business-resources/. Earlier guidance promoting physical distancing by business in certain circumstances also remains posted on the City's COVID web page as a reference. However, as of the date of this memo, the City Council has not renewed its teleconference findings, and LACERA staff is informed that in person meetings will likely resume on January 9, 2023.

The Centers for Disease Control and Prevention (CDC) recently updated its guidance, but the CDC still advises the public that they can "Prevent the Spread of COVID-19." Among the methods cited by CDC is "Keeping a Safe Distance Helps Stop COVID-19: Stay away from people who are sick. Stay away from people who have COVID-19. Stay away from people with COVID-19 even if they don't feel sick. Stay away from crowds. Stay away from inside places with lots of people." https://www.cdc.gov/coronavirus/2019-ncov/easy-to-read/prevent-getting-sick/how-covid-spreads.html.

Under these circumstances, the Boards may reasonably conclude and find that teleconferencing under Section 54953(e) is appropriate for Board and Committee meetings, including on a hybrid basis, during the next 30 days, so long as the State of Emergency remains in effect, because (1) the State of Emergency continues to impact the ability of the Trustees to meet safely in person, or (2) the County and other authorities continue to recommend measures to promote a safe workplace, including physical distancing to avoid crowding, as required by the statute. Either finding is sufficient under Section 54953(e) to support continued teleconference meetings.

If each Board makes these findings and directs teleconferencing under Section 54953(e), procedures exist and will be implemented to ensure compliance with the agenda and public comment requirements of the statute, as stated above. As required by the Boards' September 23, 2022 action, hybrid in person and teleconference meetings will be implemented in accordance with procedures required by the Brown Act.

Finally, LACERA management recently updated staff work standards in light of increased transmission and infection levels. Nevertheless, management continues to support

hybrid office/telework procedures and continues a balance between hybrid and in office work, in division manager discretion based on business needs. Management will adjust staff working conditions as required based on future changes in COVID transmission and infection rates.

CONCLUSION

Based on the above information, staff recommends that, under AB 361 and Government Code Section 54953(e)(3) of the Brown Act, the Board of Retirement and Board of Investments separately consider whether to find that the Governor's COVID-19 State of Emergency continues to directly impact the ability of each Board and its Committees to meet safely in person and that other public agencies still maintain guidelines regarding distancing such that each Board and its Committees shall hold teleconference meetings for the next 30 days as part of hybrid meetings also in person, so long as the State of Emergency remains in effect, and if so, direct staff to comply with the agenda and public comment requirements of the statute. Action taken by each Board will only apply to that Board and its Committees.

If the required findings are made, teleconference technology will be used as part of hybrid Board and Committee meetings conducted by teleconference and in person at LACERA's Pasadena offices, so long as permissible under applicable law.

c: Santos H. Kreimann, Luis A. Lugo, JJ Popowich, Jonathan Grabel, Laura Guglielmo, Carly Ntoya

LACERA

December 27, 2022

TO: Trustees, Board of Retirement

FOR: Board of Retirement Meeting on January 4, 2023

SUBJECT: Ratification of Service Retirement and Survivor Benefit Application Approvals

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The attached report reflects service retirements and survivor benefit applications received as of the date of this memo, along with any retirement rescissions and/or changes approved at last month's Board meeting. Any retirement rescissions or changes received after the date of this memo up to the date of the Board's approval, will be reflected in next month's report.

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
MECHAELLE-AN O. ALLEN	SHERIFF Dept.#SH	01-27-2023	31 YRS 01 MOS
CESAR C. BARRAGAN	SHERIFF Dept.#SH	11-30-2022	25 YRS 10 MOS
RAYMUNDO BARRERA	DISTRICT ATTORNEY Dept.#DA	01-03-2023	31 YRS 06½ MOS
MARK P. BARRETTO	SHERIFF Dept.#SH	01-01-2023	23 YRS 02½ MOS
GARY D. BUTTS	SHERIFF Dept.#SH	01-28-2023	25 YRS 00 MOS
CHRISTOPHER C. CALE	SHERIFF Dept.#SH	03-31-2023	34 YRS 04½ MOS
PETER ROBERT T. CALLADO	SHERIFF Dept.#SH	01-03-2023	32 YRS 04½ MOS
ERNESTO CARRASCO	SHERIFF Dept.#SH	01-31-2023	36 YRS 01½ MOS
BRIAN F. CHRISTY	SHERIFF Dept.#SH	02-01-2023	31 YRS 09½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
DANIAL L. DANTICE	SHERIFF Dept.#SH	01-31-2023	31 YRS ½ MOS
G DEAN DORSEY	L A COUNTY FIRE DEPT Dept.#FR	01-31-2023	31 YRS 08½ MOS
GEORGE F. GILLEN	L A COUNTY FIRE DEPT Dept.#FR	01-02-2023	25 YRS 02½ MOS
VINCENT F. GRANT	SHERIFF Dept.#SH	02-01-2023	31 YRS 03½ MOS
JEFFREY S. GRAVES	L A COUNTY FIRE DEPT Dept.#FR	12-31-2022	02 YRS 02½ MOS
MUSBAU B. HALID	L A COUNTY FIRE DEPT Dept.#FR	12-31-2022	21 YRS 01½ MOS
EUGENE G. HATCH	SHERIFF Dept.#SH	01-28-2023	33 YRS 11 MOS
SCOTT S. HENNESSY	SHERIFF Dept.#SH	02-09-2023	32 YRS 04½ MOS
MICHAEL S. KONECNY	SHERIFF Dept.#SH	02-02-2023	34 YRS ½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
JAMES F. LAMPE	L A COUNTY FIRE DEPT Dept.#FR	02-28-2023	24 YRS 00 MOS
JAMES P. LONG	SHERIFF Dept.#SH	12-31-2022	32 YRS 10½ MOS
BRADLEY W. MACK	L A COUNTY FIRE DEPT Dept.#FR	12-29-2022	02 YRS 02 MOS
MICHAEL T. MAHER	SHERIFF Dept.#SH	01-28-2023	31 YRS 09 MOS
ALBERT M. MALDONADO	SHERIFF Dept.#SH	01-31-2023	36 YRS 08½ MOS
RONNIE F. MASON	SHERIFF Dept.#SH	03-29-2023	27 YRS 00 MOS
ERNESTO MASSON	SHERIFF Dept.#SH	01-28-2023	32 YRS 08 MOS
ERIC A. MATIAS	SHERIFF Dept.#SH	12-31-2022	31 YRS 05½ MOS
JESSE C. MELGOZA	SHERIFF Dept.#SH	01-27-2023	27 YRS 10 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
JOHN B. MOORE	SHERIFF Dept.#SH	01-27-2023	36 YRS 10 MOS
PATRICK E. MORRIS	SHERIFF Dept.#SH	01-31-2023	32 YRS 06½ MOS
TIMOTHY K. MURAKAMI	SHERIFF Dept.#SH	01-28-2023	43 YRS 07 MOS
DOUGLAS A. MURAKAMI	SHERIFF Dept.#SH	01-31-2023	31 YRS 07½ MOS
SHAUN C. OATES	L A COUNTY FIRE DEPT Dept.#FR	11-18-2022	24 YRS 07 MOS
JOSEPH A. ROSALEZ	SHERIFF Dept.#SH	01-28-2023	31 YRS 08 MOS
SHAWN A. SHAW	SHERIFF Dept.#SH	01-31-2023	31 YRS 02½ MOS
RAYMOND E. TABUA	SHERIFF Dept.#SH	01-02-2023	26 YRS 09½ MOS
MICHAEL Y. TAKESHITA	L A COUNTY FIRE DEPT Dept.#FR	01-31-2023	32 YRS 08½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
JOHN J. THORNE	SHERIFF Dept.#SH	01-19-2023	31 YRS 04 MOS
CURTIS R. WISMAN	L A COUNTY FIRE DEPT Dept.#FR	01-31-2023	28 YRS 01½ MOS
LANCE A. WULTERIN	SHERIFF Dept.#SH	02-01-2023	33 YRS 06½ MOS
LAURENCE E. ZIMMERMAN	SHERIFF Dept.#SH	03-01-2023	33 YRS 01½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
MARIA B. ADEVA	CORRECTIONAL HEALTH Dept.#HC	01-31-2023	30 YRS 10½ MOS
ALEJANDRA AGUILAR	PUBLIC HEALTH PROGRAM Dept.#PH	01-28-2023	40 YRS 07 MOS
RIBHI S. AL-BADAWI	PUBLIC WORKS Dept.#PW	01-31-2023	40 YRS 05½ MOS
HEATHER D. ANDERSON	SUPERIOR COURT/COUNTY CLERK Dept.#SC	01-28-2023	34 YRS 01½ MOS
JOSEPH L. ANDRADE	PUBLIC WORKS Dept.#PW	12-30-2022	38 YRS 02 MOS
SONIA C. ANDRES	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	12-01-2022	17 YRS 01½ MOS
GENEVA E. ANKAI-TAYLOR	CHILDREN & FAMILY SERVICES Dept.#CH	01-31-2023	29 YRS 04½ MOS
DAENNA ARELLANO	SUPERIOR COURT/COUNTY CLERK Dept.#SC	01-18-2023	39 YRS 00 MOS
FRANCISCA D. ARELLANO	DISTRICT ATTORNEY Dept.#DA	01-31-2023	42 YRS 03½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
CONNIE ARENAS-MONTE	SHERIFF Dept.#SH	02-02-2023	25 YRS ½ MOS
KAMALA K. AYSOLA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-31-2022	37 YRS 01½ MOS
DAISY Q. BAIZA	CORRECTIONAL HEALTH Dept.#HC	01-31-2023	18 YRS ½ MOS
VARIN BANGCHALOTOR	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-09-2022	32 YRS 09½ MOS
SOLEDAD BARAJAS	CHILD SUPPORT SERVICES Dept.#CD	11-30-2022	27 YRS 07 MOS
PATRIA C. BASILIO	CORRECTIONAL HEALTH Dept.#HC	12-30-2022	21 YRS 03 MOS
BRUCE W. BATES	PROBATION DEPARTMENT Dept.#PB	01-25-2023	25 YRS 00 MOS
ELLEN F. BELEN	PUBLIC HEALTH PROGRAM Dept.#PH	01-28-2023	15 YRS 00 MOS
LINDA C. BELL	PUBLIC WORKS Dept.#PW	01-31-2023	25 YRS 06½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
JAMES M. BELNA	DISTRICT ATTORNEY Dept.#DA	12-31-2022	36 YRS 01½ MOS
DAVID BREAULT	ASSESSOR Dept.#AS	01-31-2023	40 YRS 08½ MOS
CYNTHIA Y. CANIER	PUBLIC HEALTH PROGRAM Dept.#PH	12-06-2022	24 YRS 06½ MOS
WENDY CARLTON	PUBLIC DEFENDER Dept.#PD	01-20-2023	01 YRS 06 MOS
SHERRI R. CARTER	SUPERIOR COURT/COUNTY CLERK Dept.#SC	12-31-2022	15 YRS 06½ MOS
FELICIA CATTRON	SUPERIOR COURT/COUNTY CLERK Dept.#SC	02-28-2023	26 YRS 00 MOS
ELENA M. CHAVEZ	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	01-28-2023	39 YRS 00 MOS
BILL CHEN	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-31-2022	21 YRS 06½ MOS
JOYCE COBBS	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	12-31-2022	41 YRS 09½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ROSEMARIE COMPEAN	CHILDREN & FAMILY SERVICES Dept.#CH	01-31-2023	32 YRS 04½ MOS
BERNADINE M. CONTRERAS-MO	SHERIFF Dept.#SH	12-31-2022	33 YRS 08 MOS
MARIA T. CORRAL	SUPERIOR COURT/COUNTY CLERK Dept.#SC	01-07-2023	39 YRS 03½ MOS
ARETTA J. COVINGTON	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	01-27-2023	37 YRS 11 MOS
RONALD L. COX	PARKS AND RECREATION Dept.#PK	01-26-2023	31 YRS 09 MOS
ROSA L. CRUZ	COUNTY COUNSEL Dept.#CC	01-30-2023	22 YRS 03 MOS
MARCIA B. DANIEL	DISTRICT ATTORNEY Dept.#DA	01-27-2023	31 YRS 01 MOS
PATRICIA DE LA GUERRA	PUBLIC DEFENDER Dept.#PD	01-03-2023	30 YRS 00 MOS
LISSETTE DE LEON	MENTAL HEALTH Dept.#MH	01-31-2023	16 YRS 04½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
AUNDRA D. DEADMON	INTERNAL SERVICES Dept.#IS	01-28-2023	45 YRS 01 MOS
NORA DEMIRJIAN	CHILD SUPPORT SERVICES Dept.#CD	12-31-2022	22 YRS 05½ MOS
CINDY L. DIEPHUYNH	SHERIFF Dept.#SH	02-24-2023	31 YRS 01 MOS
DUKE DOAN	CHIEF EXECUTIVE OFFICE Dept.#AO	03-31-2023	30 YRS 09½ MOS
RONALD L. DOCKERY JR	PUBLIC WORKS Dept.#PW	01-27-2023	19 YRS 00 MOS
ARNEL G. DULAY	PUBLIC WORKS Dept.#PW	01-31-2023	38 YRS 06½ MOS
JAMES W. EADS II	HEALTH SERVICES ADMINISTRATION Dept.#HS	12-30-2022	22 YRS 06 MOS
BEKELE ENGIDA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-30-2022	28 YRS 09 MOS
ELIZABETH A. ENTZEL	CHILDREN & FAMILY SERVICES Dept.#CH	01-28-2023	28 YRS 09 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ELIZABETH E. ERICKSON	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	03-31-2023	16 YRS 08½ MOS
GLORIA ESCAMILLA	REG-RECORDER/COUNTY CLERK Dept.#RR	01-28-2023	27 YRS ½ MOS
ESTELA ESCOBAR	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-31-2023	32 YRS ½ MOS
KEVIN L. FOUNTAIN	BEACHES & HARBORS Dept.#BH	01-13-2023	15 YRS ½ MOS
MARY T. FOWLER	INTERNAL SERVICES Dept.#IS	02-28-2023	24 YRS 01 MOS
ESTER M. GATCHALIAN	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	11-26-2022	07 YRS ½ MOS
SAEED GHAZVINI	INTERNAL SERVICES Dept.#IS	01-07-2023	10 YRS 04½ MOS
MARION D. GILL	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	12-31-2022	32 YRS 01½ MOS
NESTOR GONZALEZ-CAD	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	12-31-2022	23 YRS 07½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
RUTH GORDON	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	12-15-2022	27 YRS 08½ MOS
PATRICE M. GRANT	MENTAL HEALTH Dept.#MH	01-27-2023	31 YRS 11 MOS
DONNA M. GRAVES	MENTAL HEALTH Dept.#MH	01-27-2023	21 YRS 08 MOS
JAIME E. GUEVARA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-28-2023	15 YRS 00 MOS
MARICARMEN GUEVARA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-28-2023	20 YRS 04 MOS
ANNETTE D. GUTIERREZ	L A COUNTY FIRE DEPT Dept.#FR	12-31-2022	23 YRS 02 MOS
CARMELITA H. HEARN	PUBLIC WORKS Dept.#PW	01-01-2023	11 YRS 07 MOS
STEPHANIE HERERA CORCO	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	12-16-2022	26 YRS 04 MOS
WILLIAM HOTTRAN	PARKS AND RECREATION Dept.#PK	12-31-2022	51 YRS 04½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
LITO HUGO	ASSESSOR Dept.#AS	01-31-2023	33 YRS 01½ MOS
EMMANUEL IGTANLOC	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	01-28-2023	36 YRS 01 MOS
EDGAR H. IOBST	AGRICULTURAL COMM./WTS & MEAS. Dept.#AW	02-16-2023	18 YRS 02 MOS
DAVIL W. JACKSON	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	02-01-2023	38 YRS 03½ MOS
JORGE JARAMILLO	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-31-2022	31 YRS ½ MOS
TAMIKA L. JOHNSON	CHILD SUPPORT SERVICES Dept.#CD	11-30-2022	26 YRS 09½ MOS
TRINELL JOHNSON	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-31-2022	22 YRS ½ MOS
KATRINNA D. JONES	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-31-2023	33 YRS 04½ MOS
RASHIDI A. KAFELE	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	11-30-2022	26 YRS 03 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
GARY C. KANEL	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	01-06-2023	43 YRS 05½ MOS
HSIU-FANG T. KAO	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-28-2023	16 YRS 06 MOS
ADRINE KHATCHADOURI	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-31-2023	30 YRS 07½ MOS
JOSEPH E. KUBAN	SHERIFF Dept.#SH	01-31-2023	26 YRS 09½ MOS
MADELYN LABORIEL	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	12-16-2022	14 YRS 04 MOS
GRACE LANDAVERDE	PROBATION DEPARTMENT Dept.#PB	01-28-2023	23 YRS 00 MOS
NANCY LEE	SUPERIOR COURT/COUNTY CLERK Dept.#SC	01-14-2023	32 YRS 09½ MOS
LORNA LEJANO	CHILD SUPPORT SERVICES Dept.#CD	03-31-2023	38 YRS 04½ MOS
MARK S. LEON	PROBATION DEPARTMENT Dept.#PB	01-28-2023	33 YRS 04 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
SUSIE LEW	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-31-2023	23 YRS ½ MOS
RAYMOND P. LEWIS	INTERNAL SERVICES Dept.#IS	01-28-2023	23 YRS 08 MOS
STEVEN W. LEWIS	PUBLIC DEFENDER Dept.#PD	01-31-2023	12 YRS 01½ MOS
ELSA LEYVA	PUBLIC DEFENDER Dept.#PD	12-30-2022	19 YRS 08 MOS
ELAINE M. LOPEZ	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	01-28-2023	37 YRS 07 MOS
VERONICA LUNA	SHERIFF Dept.#SH	01-31-2023	31 YRS 10½ MOS
BRIAN A. MAHAN	CHIEF EXECUTIVE OFFICE Dept.#AO	01-28-2023	27 YRS 07 MOS
DARRELL D. MAHOOD	SUPERIOR COURT/COUNTY CLERK Dept.#SC	01-02-2023	38 YRS 09½ MOS
ARARAT MARGOOSIAN	INTERNAL SERVICES Dept.#IS	02-01-2023	20 YRS ½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
SHARON MARINO	CHILDREN & FAMILY SERVICES Dept.#CH	01-31-2023	26 YRS 11½ MOS
JOHN A. MARQUEZ	INTERNAL SERVICES Dept.#IS	12-31-2022	38 YRS 06½ MOS
ALMA D. MARTINEZ	PUBLIC WORKS Dept.#PW	12-30-2022	25 YRS 02 MOS
LORRAINE T. MARTINEZ	SHERIFF Dept.#SH	12-30-2022	26 YRS 05 MOS
ARLENE A. MARTINEZ	CORRECTIONAL HEALTH Dept.#HC	01-31-2023	35 YRS 03½ MOS
GARY L. MC CULLOUCH	INTERNAL SERVICES Dept.#IS	01-14-2023	33 YRS 04½ MOS
LUZVIMINDA R. MENESES	CHILDREN & FAMILY SERVICES Dept.#CH	01-31-2023	14 YRS 09½ MOS
RALPH MILLER	PROBATION DEPARTMENT Dept.#PB	12-03-2022	43 YRS 11½ MOS
DERLYNN MILLER	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	12-15-2022	30 YRS 01 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ESPERANCA V. MONIZ	PUBLIC HEALTH PROGRAM Dept.#PH	03-01-2023	09 YRS 02½ MOS
JUDY L. MOORE	MENTAL HEALTH Dept.#MH	01-31-2023	17 YRS 01½ MOS
SYLVIA Y. MORA	PROBATION DEPARTMENT Dept.#PB	01-23-2023	25 YRS 00 MOS
MARIE D. MORABE	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	12-27-2022	33 YRS 03½ MOS
DENNIS R. MORALES	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	12-31-2022	40 YRS 03½ MOS
DULCE M. MORAN	SUPERIOR COURT/COUNTY CLERK Dept.#SC	12-31-2022	44 YRS 01½ MOS
PILAR M. MORENO	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-31-2023	32 YRS 09½ MOS
JEFFREY MORGAN	HEALTH SERVICES ADMINISTRATION Dept.#HS	01-28-2023	33 YRS 03 MOS
MANSOOR MOSHREFI	L A COUNTY FIRE DEPT Dept.#FR	01-28-2023	27 YRS 08 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ARTHUR R. MUNOZ	INTERNAL SERVICES Dept.#IS	01-28-2023	30 YRS 00 MOS
JEFFREY NARANJO	CHILD SUPPORT SERVICES Dept.#CD	01-31-2023	25 YRS 03½ MOS
DIVINA NAVARRO	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-28-2023	32 YRS 02 MOS
ESTHER C. NOLBERTO	SHERIFF Dept.#SH	01-31-2023	14 YRS ½ MOS
MICHELLE R. PALMER	PUBLIC HEALTH PROGRAM Dept.#PH	12-31-2022	22 YRS 02½ MOS
VIRGINIA PARDO	CHILDREN & FAMILY SERVICES Dept.#CH	12-30-2022	14 YRS 08 MOS
MARIE PASSI	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-31-2022	25 YRS 10 MOS
ANITA D. PERGLER	SUPERIOR COURT/COUNTY CLERK Dept.#SC	01-31-2023	39 YRS 01½ MOS
BANG D. PHAM	HEALTH SERVICES ADMINISTRATION Dept.#HS	11-30-2022	17 YRS 02 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
GREGORY C. POLK	MENTAL HEALTH Dept.#MH	02-01-2023	30 YRS 02½ MOS
CHI K. QUAN	PROBATION DEPARTMENT Dept.#PB	01-31-2023	21 YRS ½ MOS
JERRY QUINONES	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	01-28-2023	37 YRS 02 MOS
YOLANDA QUINTERO	AMBULATORY CARE NETWORK Dept.#HN	12-31-2022	33 YRS 06½ MOS
PHUONG QUOI	SUPERIOR COURT/COUNTY CLERK Dept.#SC	11-28-2022	33 YRS 10 MOS
MAJID RANJBAR	PUBLIC WORKS Dept.#PW	02-25-2023	36 YRS 09 MOS
ROSEMARY P. RANSOM	CHILD SUPPORT SERVICES Dept.#CD	12-30-2022	41 YRS 05 MOS
STEPHEN J. RIVERA	MENTAL HEALTH Dept.#MH	01-31-2023	17 YRS 03½ MOS
MARY C. RIVERA	ANIMAL CONTROL Dept.#AN	01-31-2023	10 YRS ½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ANGELINA ROBLES	CHILDREN & FAMILY SERVICES Dept.#CH	01-28-2023	28 YRS 07 MOS
CYNTHIA RODARTE	DISTRICT ATTORNEY Dept.#DA	12-30-2022	06 YRS 08 MOS
LEAH N. ROMERO	AMBULATORY CARE NETWORK Dept.#HN	12-31-2022	11 YRS ½ MOS
FLORITA ROSARIO	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	01-31-2023	15 YRS 05½ MOS
SILVIA ROSAS-WHITE	CHILDREN & FAMILY SERVICES Dept.#CH	12-31-2022	37 YRS 10 MOS
YVONNE M. SALAS	SHERIFF Dept.#SH	01-31-2023	38 YRS 03½ MOS
BEATRICE SANCHEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-28-2023	36 YRS 07 MOS
SERGIO J. SANTANA	PARKS AND RECREATION Dept.#PK	01-28-2023	39 YRS 09½ MOS
MARA SERRATO	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	02-28-2023	31 YRS 02 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
TAHEREH SHADLOO	PUBLIC HEALTH PROGRAM Dept.#PH	01-31-2023	35 YRS 05½ MOS
DEBORAH SILVERA	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	11-30-2022	31 YRS 02 MOS
ANITA T. SIU	JUVENILE COURT HEALTH SERVICES Dept.#HJ	01-03-2023	13 YRS 03½ MOS
DEBORAH SMITH	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-31-2022	32 YRS 06½ MOS
SUSAN F. STEINFELD	DISTRICT ATTORNEY Dept.#DA	12-30-2022	29 YRS 02 MOS
LEANNE M. STEINHAUS	PROBATION DEPARTMENT Dept.#PB	01-28-2023	37 YRS 08 MOS
BRENDA L. STEWART	SHERIFF Dept.#SH	12-31-2022	35 YRS 05 MOS
EVELYN M. STONE	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	12-15-2022	30 YRS 05½ MOS
ALISON J. STONEHAM	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	12-15-2022	44 YRS 11½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
KAREN TAMBARA	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	12-05-2022	26 YRS 08 MOS
JIN-LING W. TANG	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-27-2023	36 YRS 05 MOS
DAMELLE L. TATE	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-01-2022	25 YRS 03 MOS
FREDERICK L. TAYLOR	PROBATION DEPARTMENT Dept.#PB	01-28-2023	41 YRS 03 MOS
JOHN P. THAI	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-03-2023	23 YRS ½ MOS
FRANCINE A. THOMAS	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-30-2022	42 YRS 01 MOS
DIANE L. THORNE	PARKS AND RECREATION Dept.#PK	01-26-2023	28 YRS 04 MOS
PHILIP M. TSE	PUBLIC WORKS Dept.#PW	01-27-2023	20 YRS 06 MOS
JOSE VALDEZ	SUPERIOR COURT/COUNTY CLERK Dept.#SC	02-01-2023	27 YRS 06½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
MICHAEL WADE	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	01-31-2023	33 YRS 05½ MOS
ALBERT J. WAINIE	SHERIFF Dept.#SH	12-31-2022	39 YRS 04½ MOS
THOMAS E. WILCOX	PROBATION DEPARTMENT Dept.#PB	02-23-2023	14 YRS 06 MOS
CELESTE C. WILSON	SHERIFF Dept.#SH	12-31-2022	26 YRS 01½ MOS
DAVID M. WONG	PROBATION DEPARTMENT Dept.#PB	01-31-2023	31 YRS 05½ MOS
MERCEDES D. ZEPEDA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	01-31-2023	38 YRS 08½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL SURVIVOR APPLICATIONS

NAME	DEPARTMENT	RETIRED	SERVICE
CHERISSE M. GOEDHART	PARKS AND RECREATION Dept.#PK	10-18-2022	16 YRS 10½ MOS
MICHELLE V. HERRERA-GOME	L A COUNTY FIRE DEPT Dept.#FR	09-28-2022	08 YRS ½ MOS
SPOUSE of ARTHUR J GOMEZ dec'd on 09-27-2022, Sect. #31781.1			
HIROKO SAKO	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	08-30-2022	21 YRS 11 MOS
WIFE of JEFFREY CHEN dec'd on 08-29-2022, Sect. #31781.1			

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
JAMES R. BROWN	SHERIFF Dept.#SH	12-30-2022	05 YRS 07 MOS
PAUL W. HEATER	SHERIFF Dept.#SH	11-02-2022	07 YRS 00 MOS
JENNIFER C. THRALL	SHERIFF Dept.#SH	11-03-2022	06 YRS 06 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
STEVEN BERLIN	SHERIFF Dept.#SH	12-26-2022	41 YRS 03 MOS
RENEE D. BUGARIN	L A COUNTY FIRE DEPT Dept.#FR	12-09-2022	19 YRS 01 MOS
LARRY S. COOK	PUBLIC WORKS Dept.#PW	01-06-2023	21 YRS 08½ MOS
ROSALIN DENISE	PROBATION DEPARTMENT Dept.#PB	11-25-2022	34 YRS 02½ MOS
CYNTHIA A. ESCO	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-19-2022	36 YRS 06 MOS
ZOHAR ETS HADAR	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	12-19-2022	06 YRS 02 MOS
YESENIA GONZALEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	11-01-2022	02 YRS 11 MOS
ROZLYN D. GORDON	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	11-21-2022	11 YRS 10 MOS
EUGENE P. HANRAHAN	DISTRICT ATTORNEY Dept.#DA	11-09-2022	21 YRS 05 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
LORI J. JOHNSON	HEALTH SERVICES ADMINISTRATION Dept.#HS	12-04-2022	42 YRS 04 MOS
CRISTINA LEDESMA-JONA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	11-14-2022	28 YRS 09 MOS
GENE K. LUI	PUBLIC WORKS Dept.#PW	11-16-2022	10 YRS 01 MOS
GINA M. MAHOOD	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	11-18-2022	13 YRS 00 MOS
TERESA S. MASCETTI	SUPERIOR COURT/COUNTY CLERK Dept.#SC	12-09-2022	18 YRS 01 MOS
JOHN C. MATTIA	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	09-28-2022	10 YRS 06 MOS
ROSEMARY N. MWANGI	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	12-01-2022	13 YRS 10½ MOS
MICHAEL NEWMAN	CHILDREN & FAMILY SERVICES Dept.#CH	12-03-2022	11 YRS 09 MOS
ERIKA R. NWUDE	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	11-09-2022	12 YRS 01½ MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
MATTHEW A. OJO	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	11-01-2022	03 YRS 02 MOS
OLIVIA L. PADILLA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	12-01-2022	27 YRS 09 MOS
ANGELA L. POINTER	SHERIFF Dept.#SH	11-16-2022	11 YRS 04 MOS
JOSEPH R. PORRAS	SUPERIOR COURT/COUNTY CLERK Dept.#SC	12-22-2022	13 YRS 08 MOS
ALAN C. PUCCIARELLI	OFFICE OF PUBLIC SAFETY Dept.#SY	12-31-2022	15 YRS 11 MOS
MARIA L. SALAZAR	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	11-15-2022	13 YRS 02 MOS
ROBERT M. SMITH	PUBLIC WORKS Dept.#PW	11-18-2022	18 YRS 09 MOS
ALLEN T. THOMPSON	PUBLIC WORKS Dept.#PW	12-31-2022	19 YRS 07 MOS
CHARLES E. TOVAR	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	01-01-2023	10 YRS 07 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
CYNTHIA D. WALKER	ASSESSOR Dept.#AS	11-16-2022	20 YRS 01 MOS
MICHAEL WILLIAMS	PUBLIC LIBRARY Dept.#PL	12-20-2022	11 YRS 04 MOS

BOARD OF RETIREMENT MEETING OF JANUARY 4, 2023
RESCISSIONS/CHANGES FROM BENEFIT APPROVAL LIST
APPROVED ON DECEMBER 7, 2022

SAFETY MEMBER APPLICATIONS FOR SERVICE RETIREMENT

NAME	DEPARTMENT	UPDATE
DION D BALLENTINE	SHERIFF	CHANGE OF DATE TO January 3, 2023
GREGORY D MCKNIGHT	SHERIFF	CHANGE OF DATE TO March 31, 2023

GENERAL MEMBER APPLICATIONS FOR SERVICE RETIREMENT

NAME	DEPARTMENT	UPDATE
MARK W YOUNG	PUBLIC WORKS	RESCISSION OF RETIREMENT
OSCAR OLGUIN	DEPT OF PUBLIC SOCIAL SERVICES	RESCISSION OF RETIREMENT
ADRIAN P GAYTAN	PROBATION DEPARTMENT	RESCISSION OF RETIREMENT
FAYON D TILLMAN	SHERIFF	CHANGE OF DATE TO December 15, 2022
LILIAN ONG	DEPT OF PUBLIC SOCIAL SERVICES	CHANGE OF DATE TO November 30, 2022
TARIK ABRAHA	DEPT OF PUBLIC SOCIAL SERVICES	RESCISSION OF RETIREMENT
CARMEN CANTO YOUNG	COASTAL CLUSTER-HARBOR/UCLA MC	RESCISSION OF RETIREMENT
GINA E GRIMALDI	AMBULATORY CARE NETWORK	CHANGE OF DATE TO January 17, 2023
ALICIA VERA	PUBLIC HEALTH PROGRAM	RESCISSION OF RETIREMENT

LACERA

December 20, 2022

TO: Each Member
Board of Retirement

FROM: Insurance, Benefits and Legislative Committee
Les Robbins, Chair
Vivian H. Gray, Vice Chair
Shawn R. Kehoe
Wayne Moore
Herman Santos, Alternate

FOR: January 4, 2023 Board of Retirement Meeting

SUBJECT: **Federal Engagement – Visit with Congress**

RECOMMENDATION
That the Board of Retirement:

1. Approve a visit with Congress by Board trustees as designated by the Chair of the Board of Retirement and by staff as designated by the Chief Executive Officer during the week of January 22, 2023 in Washington, D.C.; and
2. Approve reimbursement of all travel costs incurred in accordance with LACERA's Trustee Travel Policy.

LEGAL AUTHORITY
The Board of Retirement's Policy on Engagement for Public Policy Issues Relating to Plan Administration and Retirement and Health Care Benefits provides for engagement to promote LACERA's presence and visibility with the legislative, executive, and judicial branches of state and federal governments.

DISCUSSION
The California Delegation consisting of 52 representatives and 2 senators is the largest in Congress. Board members and staff have engaged with members of Congress and their staff on previous visits to Washington, D.C., most recently in May 2022. The visit is a continuing effort of engagement to foster relationships with members of Congress by increasing LACERA's presence and visibility among the members and providing education and information about LACERA's history, organization, and operations.

Since the visit will take place soon after the recent midterm elections and at the start of a new 118th Congress, it will be an opportunity to continue expanding outreach to other members of the California Delegation. The visit will also be an opportunity to continue engagement with Congress on the repeal of the Windfall Elimination Provision, the Government Pension Offset, and the direct payment requirement of healthcare premiums

from the pension distributions of public safety officers as well as educating Congressional members about LACERA.

The National Conference on Public Employee Retirement Systems (NCPERS) will be holding its annual Legislative Conference on January 22-24, 2023 in Washington D.C. LACERA's federal legislative advocate, Tony Roda of Williams & Jensen, may be able to schedule Congressional meetings following the NCPERS Legislative Conference. The visit to Congress would ideally be available to those Board trustees and staff who are already in Washington, D.C., for the pre-approved NCPERS conference to visit with Congress afterwards; scheduling the visit immediately after the NCPERS conference is an efficient way to save on air travel costs that would otherwise be incurred if the visit were scheduled on a separate occasion.

IT IS THEREFORE RECOMMENDED THAT THE BOARD:

1. Approve a visit with Congress by Board trustees as designated by the Chair of the Board of Retirement and by staff as designated by the Chief Executive Officer during the week of January 22, 2023 in Washington, D.C.; and
2. Approve reimbursement of all travel costs incurred in accordance with LACERA's Trustee Travel Policy.

Attachment
NCPERS 2023 Legislative Conference Brochure

cc: Santos H. Kreimann
Luis Lugo
JJ Popowich
Laura Guglielmo
Steven P. Rice
Cassandra Smith
Tony Roda, Williams & Jensen
Shane Doucet, Doucet Consulting Solutions

ADVOCACY | RESEARCH | EDUCATION

2023 LEGISLATIVE CONFERENCE

January 22–24
Renaissance Washington, DC Hotel
Washington, DC

2023 PENSION COMMUNICATIONS SUMMIT

January 23–24
Renaissance Washington, DC Hotel
Washington, DC

Attend both conferences and save $150 on registration!
Early-bird registration deadline is Thursday, January 5

@NCPERS @NCPERS @National Conference on Public Employee Retirement Systems

ABOUT THE LEGISLATIVE CONFERENCE

As the first program in the calendar year, the NCPERS Legislative Conference sets the advocacy agenda for the remainder of the year. Scheduled in January, the Legislative Conference directs the public pension industry's advocacy effort and legislative strategy to Congress and the Administration. In succinct sessions that are informative and fast-paced, attendees will hear from members of Congress, Hill staff, Administration officials, and Washington decision makers on key issues that affect pension funds today.

WHO SHOULD ATTEND

Pension trustees, pension staff members, plan sponsors, and public plan stakeholders. Service providers to the public pension community should also attend to understand the critical issues affecting clients and prospective clients.

WHY YOU SHOULD ATTEND

The Legislative Conference provides you with a great opportunity to learn about the numerous federal issues that may impact your fund. The educational sessions will equip you with the knowledge to confidently advocate on behalf of your plan and educate policy makers about the wonderful work your fund does day in and day out.

DAY 1

Hear from policy makers and experts on the critical issues related to pension funds and the current policies affecting them. Connect with other fund professionals and industry service providers for practical information and lasting peer relationships.

DAY 2

Visit your elected leaders! We've prepared you with the education, so now you can take this knowledge and meet face-to-face with your members of Congress or their staff. We strongly encourage you to **make your appointments with your elected leaders in advance of the conference** as many congressional offices do not take drop-in visitors.

KEYNOTE SPEAKER

GEOFF BENNETT

PBS NewsHour Chief Washington Correspondent & Weekend Anchor

PBS NewsHour chief Washington correspondent and weekend anchor Geoff Bennett is a long-standing, sought-after presence on America's leading media outlets known for his compelling breakdown of the political issues and current events shaping our country. An acclaimed journalist, he has reported from the White House under three presidents and covered five presidential elections, and his exclusive interviews with many of Washington, DC's most influential figures have grabbed national headlines. He has mastered the art of reporting first and accurately and is renowned for his ability to draw out in-depth insights that get to the heart of the matter and keep the American people informed.

LEGISLATIVE CONFERENCE PRELIMINARY AGENDA

Agenda is subject to change.

Sunday, January 22

3:00 PM – 6:00 PM Registration

5:00 PM – 6:00 PM Networking Reception

Monday, January 23

7:00 AM – 6:30 PM Registration

7:00 AM – 8:00 AM Breakfast

8:00 AM – 12:00 PM General Session I

- Overview of the 2022 Mid-Term Elections
- NCPERS 2023 Federal Policy Agenda
- 2023 Agenda of the US Congress
- ESG Investing Roundtable
- Secure Act 2.0
- How to Lobby Congress

12:00 PM – 1:00 PM Lunch

1:00 PM – 5:00 PM General Session II

- 2022 Policy maker of the Year Award
- Department of Treasury's Pension Activities for 2023
- State Pension Outlook: State-By-State Analysis
- GAO Retirement Security Report

5:30 PM – 6:30 PM Legislative Conference and Communications Summit Networking Reception

Tuesday, January 24

7:00 AM – 8:00 AM Legislative Conference and Communications Summit Networking Breakfast

ALL DAY Congressional Visits (self-directed) - *Schedule your appointments before coming to DC!*

8:00 AM – 4:00 PM Pension Communications Summit
(Separate registration required. Legislative Conference attendees save $150 on registration fees.)

QUESTIONS? Contact NCPERS at 202-601-2445 or registration@NCPERS.org.

ABOUT THE PENSION COMMUNICATIONS SUMMIT

NCPERS is launching the Pension Communications Summit to address the unique communications and marketing challenges that public pension plans and industry stakeholders face. The agenda will be set by fellow public pension communications professionals–members of NCPERS Communications Roundtable–and will feature peer-to-peer learning, networking opportunities, and hands-on training from industry experts.

You'll walk away with new ideas for how to address your fund's most pressing communications-related challenges, make valuable new connections, and gain knowledge of industry best practices.

WHO SHOULD ATTEND

All public pension professionals who work or have an interest in external or internal communications.

WHY YOU SHOULD ATTEND

The Pension Communications Summit is designed to celebrate and accelerate the role of the public plan communicator. Whether your role is dedicated to communications–or it's just one of your many responsibilities–this program is meant for you. It's also a venue to connect with industry peers and learn from the experience of others.

QUESTIONS? Contact NCPERS at 202-601-2445 or registration@NCPERS.org.

PENSION COMMUNICATIONS SUMMIT PRELIMINARY AGENDA

Agenda is subject to change.

Monday, January 23

3:00 PM – 6:30 PM Registration

5:30 PM – 6:30 PM Legislative Conference and Communications Summit Networking Reception

Tuesday, January 24

7:00 AM – 8:00 AM Legislative Conference and Communications Summit Breakfast

7:00 AM – 4:00 PM Registration

8:00 AM – 9:45 AM Member Engagement

- Strategies for engaging with members of all ages
- Developing a 360 communications plan and how to measure its impact
- Best practices for communicating complex information with members

10:00 AM – 12:30 PM Digital Communications and Content Development

- Tips for developing effective content (and how to maximize existing content)
- The role of social media in your overall communications strategy
- How to break through the inbox clutter and increase e-mail engagement

12:30 PM – 1:45 PM Networking Lunch

1:45 PM - 2:45 PM Media Relations: Telling Your Fund's Story

- Developing compelling narratives for the media (both proactively and reactively)
- Crisis communications do's and don'ts
- How to effectively engage with media as part of your advocacy efforts

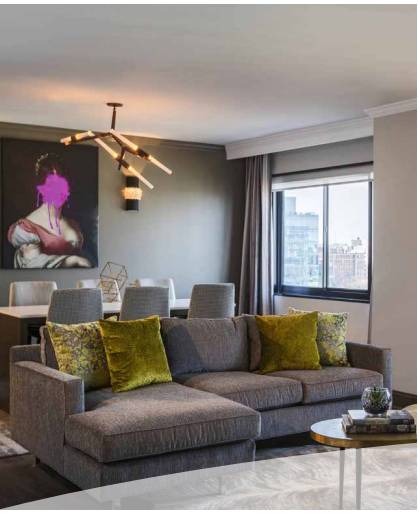
3:00 PM - 4:00 PM Facilitated Open Discussion

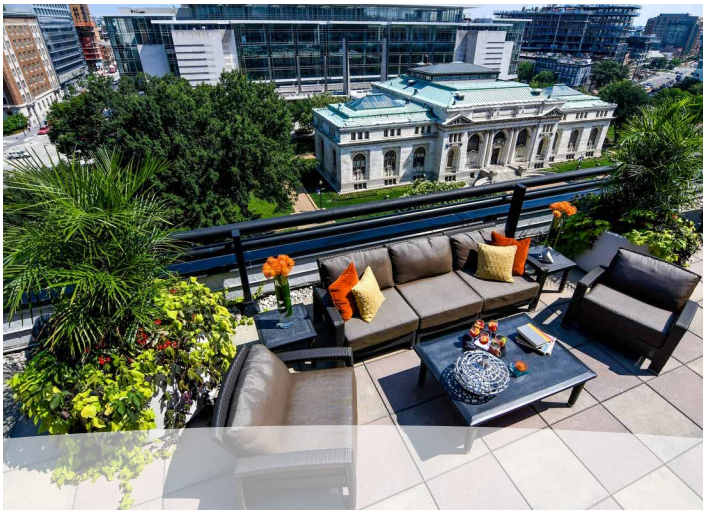
- Ask questions and learn from peers during a facilitated open discussion

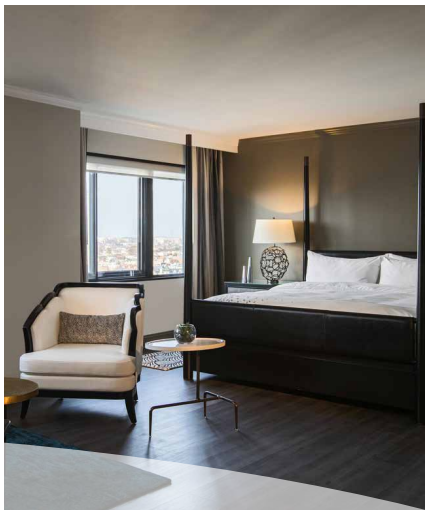
HOTEL INFORMATION

Rennaissance Washington, DC Hotel

999 Ninth Street NW | Washington, DC 20001 | 202-898-9000







Book your hotel room at the Renaissance Washington, DC Hotel, official location of the Legislative Conference and the Communications Summit. The NCPERS discounted room rate is subject to the availability of the group block. This rate is not guaranteed if you plan to arrive early or depart at a later date.

BOOKING DEADLINE: THURSDAY, JANUARY 5

ROOM RATE
$299 single/double occupancy per night

PHONE RESERVATIONS
1-800-468-3571 and mention NCPERS

ONLINE RESERVATIONS
www.NCPERS.org/legislative-conference-hotel

TRANSPORTATION

AIRPORTS

5 miles from Ronald Reagan Washington National Airport (DCA)

Type	Minimum Charge
Subway/Rail	$2.50
Taxi	$20.00

25 miles from Washington Dulles International Airport (IAD)

Type	Minimum Charge
Taxi	$55.00

30 miles from Baltimore/Washington International Airport (BWI)

Type	Minimum Charge
Subway/Rail	$25.00
Taxi	$85.00

GENERAL INFORMATION

COVID-19 POLICY

It is NCPERS policy that during the COVID-19 pandemic, attendees of in-person meetings must adhere to the following rules:

- **Must adhere to local or the venue's social distancing protocols, even if fully vaccinated**
- **Must respect personal space and contact preferences of other attendees and staff, as indicated by the color coding**

MEMBERSHIP STATUS

This is a members-only conference. Your organization must be a current member of NCPERS in order for your registration to be processed. To verify your organization's membership status, please e-mail membership@ncpers.org.

CONTINUING EDUCATION (CE) CREDITS

NCPERS is recognized as a learning provider in the public pension industry and is an accredited sponsor of continuing education in several states.

- 2023 Legislative Conference = up to eight hours of CE
- 2023 Communications Summit = up to five hours of CE

REGISTRATION FEES

Registration fees include (unless otherwise noted) the following events:

- Conference materials
- Breakfast / Lunch / Refreshment breaks / Receptions

The registration fee does not include hotel accommodations, airfare, or transportation.

GUEST REGISTRATION

A guest refers to a spouse or personal friend, not a business associate, staff member, or colleague. All guests must be registered to attend NCPERS events. No admittance will be given to guests without a registration name badge.

The guest fee includes access to the following functions:

- Breakfast (valued at $65 per person)
- Receptions (valued at $85 per person)

Note: Guests will not be admitted to the lunch, as this is an educational event.

REGISTRATION DEADLINE

Register by Friday, January 5, to receive the early-bird conference rates and be included in the preliminary attendee list (this list is used by our service providers to send invitations to their client events). You may still register for the conference after this date, but higher conference fees will apply.

ATTENDEE LISTS

The preliminary attendee list will be available after the January 5 early-bird registration deadline. The list will be e-mailed to all registered attendees.

To request a copy of the list, e-mail registration@ncpers.org. To be included on this list, please register BEFORE January 5.

The final attendee list will be available on-site at the conference.

MEMBER EVENT/INVITATIONS

Service providers should not schedule/host client events during any NCPERS activities. We also require that you do not host client events with organizations/companies that are not members of NCPERS.

- If you would like your event invitation e-mailed to attendees, please contact Cassandra Smoot at 202-601-2447 or cassandra@NCPERS.org.
- If you are looking for co-hosts for your event, here is a list of our CorPERS members who would make great partners for your event. You can also search our Service Provider Member Directory.

REGISTRATION CHANGES

All registration changes must be received in writing. Please e-mail all registration changes to registration@NCPERS.org or fax to 202-688-2387.

CANCELLATIONS

All registration cancellations must be received in writing before January 5 to receive a refund and will be subject to a processing fee of $50. No refunds will be given to cancellations received after January 5 or to no-shows. All COVID19-related refunds will be approved on a case by case basis.

Please e-mail your cancellation request to registration@ncpers.org or call 202-601-2445.

REGISTRATION METHODS

Submit your registration online at www.NCPERS.org. You will need your individual username and password to log in.

E-mail the registration form directly to registration@ncpers.org.

Fax the registration form to 202-688-2387.

Mail the registration form to:
NCPERS
1201 New York Avenue, NW
Suite 850
Washington, DC 20005

2023 LEGISLATIVE CONFERENCE AND COMMUNICATONS SUMMIT REGISTRATION FORM

LEGISLATIVE REGISTRATION		
	Early-Bird Registration Rate (Through January 5)	**Late Registration Rate (After January 5)**
Fund Member	☐ $515/person	☐ $615/person
Service Provider	☐ $825/person	☐ $925/person

COMMUNICATIONS SUMMIT REGISTRATION		
	Early-Bird Registration Rate (Through January 5)	**Late Registration Rate (After January 5)**
Fund Member	☐ $250/person	☐ $350/person
Service Provider	☐ $450/person	☐ $550/person

ATTEND BOTH CONFERENCES AND RECEIVE A $150 DISCOUNT!

First Name:_____

Last Name:_____

Title:_____

Organization Name:_____

Preferred Mailing Address:_____

City: _____ State: _____ Zip Code: _____

Daytime Phone:_____

E-mail Address*:_____

**Please provide your e-mail address for conference updates and registration confirmation.*

GUEST REGISTRATION		
	Early-Bird Registration Rate (Through January 5)	**Late Registration Rate (After January 5)**
Guest	☐ $50/person	☐ $75/person

A guest refers to a spouse or personal friend, not a business associate, staff member, or colleague. All guests must be registered to attend NCPERS events. The registration fee covers all breakfasts and receptions. Guest registration does not include NAF events.

First Name: _____ Last name:_____

First Name: _____ Last name:_____

REGISTRATION/ORDER SUMMARY

Legislative Conference Registration $_____

Communications Summit Registration $_____

**$150 Less if attending both*

Guest Registration $_____

GRAND TOTAL (US funds) **$** _____

PAYMENT METHOD

All payments must be in US funds.

Electronic payment is strongly encouraged.

ONLINE at www.ncpers.org. You will need your username and password to log in.

E-MAIL completed registration to registration@ncpers.org.

FAX completed registration to 202-688-2387.

CHECK: Mail to NCPERS at 1201 New York Avenue, NW, Suite 850, Washington, DC 20005.

CREDIT CARD

☐ American Express ☐ Visa ☐ MasterCard

Credit Card #: _____

Expiration Date: _____ CC Verification Code:_____

Name on the Card:_____

Billing Address:_____

City:_____State:_____ Zip: _____

Authorized Amount to Charge: $_____

By submitting this form, I certify I have read and understand the terms of this registration. If paying by credit card, I authorize NCPERS to charge my card for the total amount indicated.

Signature:_____

CANCELLATION POLICY

All registration cancellations must be received in-writing before January 5 to receive a refund and will be subject to a processing fee of $50. **No refunds will be given to cancellations received after January 5 or to no-shows.** All COVID19-related refunds will be approved on a case-by-case basis. Please e-mail your cancellation request to registration@ncpers.org or call 202-601-2445.

QUESTIONS?

Contact NCPERS at 202-601-2445 or registration@NCPERS.org.

SPONSORSHIP

Don't miss the chance to create greater visibility for your company by being a vital part of these unique and valued educational conferences.

GOLD
$10,000

The Gold package level includes:

- Two (2) complimentary registrations.
- Branding at both conferences recognizing your organization as the sponsor of the Legislative Conference and Pension Communications Summit.
- Sponsors acknowledgment in opening general session.
- Sponsor acknowledgment in any printed materials.
- Sponsor acknowledgment on conference webpage.

SILVER
$5,000

The Silver package level includes:

- One (1) complimentary registration.
- Branding at one conference recognizing your organization as either the sponsor of the Legislative Conference or Pension Communications Summit.
  Choose one:
  - ☐ Legislative Conference
  - ☐ Pension Communications Summit
- Sponsors acknowledgment in opening general session.
- Sponsor acknowledgment in any printed materials.
- Sponsor acknowledgment on conference webpage.

BRONZE
$2,500

The Bronze package level includes:

- Branding at conference recognizing your organization as a sponsor.
- Sponsors acknowledgment in opening general session.
- Sponsor acknowledgmentin any printed materials.
- Sponsor acknowledgmenton conference webpage.

CUSTOMIZED SPONSORSHIPS

Customized sponsorship opportunities available upon request. Please contact Cassandra Smoot for more details at cassandra@ncpers.org or 202-601-2447.

SUPPORT AGREEMENT AND REGISTRATION

By completing and signing this support commitment form, the below-mentioned organization agrees to support the conference at the level selected. NCPERS agrees to comply with the terms for the selected level of support. Refunds or cancellations will not be allowed for sponsorships.s.

Organization Name: _____

First Name: _____ Last Name: _____

Preferred Mailing Address: _____

City: _____ State: ____ Zip Code: _____

Daytime Phone: _____

E-mail Address: _____

Signature: _____

PAYMENT METHOD

All payments must be in U.S. funds.

Electronic payment is strongly encouraged due to the current pandemic.

E-MAIL completed registration to registration@ncpers.org.

FAX completed registration to 202-688-2387.

Mail to NCPERS at
1201 New York Avenue, NW, Suite 850,
Washington, DC 20005

CREDIT CARD

☐ American Express ☐ Visa ☐ MasterCard

Credit Card #: _____

Expiration Date: _____ CC Verification Code: _____

Name on the card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Authorized Amount to Charge: $ _____

By submitting this form, I certify I have read and understand the terms of this sponsorship.
If paying by credit card, I authorize NCPERS to charge my card for the total amount indicated.

Signature: _____

SPONSORSHIP CANCELLATION POLICY

Sponsorship is not confirmed until full payment has been received. Once confirmed by NCPERS, sponsorship commitments are non-refundable.

For more information on sponsorship packages, please contact Cassandra Smoot at 202-601-2447.

LACERA

December 19, 2022

TO: Trustees – Board of Retirement

FROM: Fern M. Billingy
Senior Staff Counsel

DATE: Board of Retirement Meeting of January 4, 2023

SUBJECT: **COMPENSATION EARNABLE AND PENSIONABLE COMPENSATION**

INTRODUCTION

The Board of Retirement is charged with determining which items of compensation qualify as pensionable earnings includable in the member's retirement allowance. The Chief Executive Office of the County of Los Angeles recently requested determination of items of compensation. Based on our review, we have included recommendations regarding inclusion or exclusion within the definition of "final compensation" when calculating a member's benefit. Our analysis of these items is attached as Exhibit A for review.

COMPENSATION EARNABLE

In January of 1998, the Board determined that, pursuant to the California Supreme Court's decision in Ventura County Deputy Sheriff's Association v. County of Ventura (1997) 16 Cal. 4th 483, certain items of remuneration must be included in the definition of "compensation earnable." The Board then adopted Resolution 98-001 identifying those items. Since that time, other Resolutions have been adopted when new items of compensation are determined to be included in or excluded from the definition of "compensation earnable." In making those determinations, the Board reviewed analysis of all items of compensation and adopted recommendations from the Legal Office regarding the definition of "compensation earnable."

Section 31461 defines "compensation earnable." It states:

(a) "Compensation earnable" by a member means the average compensation as determined by the board, for the period under consideration upon the basis of the average number of days ordinarily worked by persons in the same grade

orclass of positions during the period, and at the same rate of pay. The computation for any absence shall be based on the compensation of the position held by the member at the beginning of the absence. Compensation, as defined in Section 31460, that has been deferred shall be deemed "compensation earnable" when earned, rather than when paid.

(b) "Compensation earnable" does not include, in any case, the following:

(1) Any compensation determined by the board to have been paid to enhance a member's retirement benefit under that system. That compensation may include:

(A) Compensation that had previously been provided in kind to the member by the employer or paid directly by the employer to a third party other than the retirement system for the benefit of the member, and which was converted to and received by the member in the form of a cash payment in the final average salary period.

(B) Any one-time or ad hoc payment made to a member, but not to all similarly situated members in the member's grade or class.

(C) Any payment that is made solely due to the termination of the member's employment, but is received by the member while employed, except those payments that do not exceed what is earned and payable in each 12-month period during the final average salary period regardless of when reported or paid.

(2) Payments for unused vacation, annual leave, personal leave, sick leave, or compensatory time off, however denominated, whether paid in a lump sum or otherwise, in an amount that exceeds that which may be earned and payable in each 12-month period during the final average salary period, regardless of when reported or paid.

(3) Payments for additional services rendered outside of normal working hours, whether paid in a lump sum or otherwise.

(4) Payments made at the termination of employment, except those payments that do not exceed what is earned and payable in each 12-month period during the final average salary period, regardless of when reported or paid.

(c) The terms of subdivision (b) are intended to be consistent with and not in conflict with the holdings in Salus v. San Diego County Employees Retirement Association (2004) 117 Cal.App.4th 734 and In re Retirement Cases (2003) 110 Cal.App.4th 426.

PENSIONABLE COMPENSATION

With the enactment of the California Public Employees' Pension Act of 2013 (PEPRA), new members are subject to the definition of "pensionable compensation" in Section 7522.34(a), which states:

> "Pensionable compensation" of a new member of any public retirement system meansthe normal monthly rate of pay or base pay of a member paid in cash to similarly situated members of the same group or class of employment for services rendered ona full-time basis during normal working hours, pursuant to publicly available pay schedules. (Emphasis added).

This section provides that any compensation outside of base pay may not be included in final compensation when calculating a member's retirement allowance. However, "base pay" is not defined in the statute. The section goes on to specifically delineate which items of compensation should be excluded.

Subdivision (c) states:

> "Pensionable compensation" does not include the following:
>
> (1) Any compensation determined by the board to have been paid to increase a member's retirement benefit under that system.
>
> (2) Compensation that had previously been provided in kind to the member by the employer or paid directly by the employer to a third party other

than the retirement system for the benefit of the member and which was converted to and received by the member in the form of a cash payment.

(3) Any one-time or ad hoc payments made to a member.

(4) Severance or any other payment that is granted or awarded to a member in connection with or in anticipation of a separation from employment, but is received by the member while employed.

(5) Payments for unused vacation, annual leave, personal leave, sick leave, or compensatory time off, however denominated, whether paid in a lump sum or otherwise, regardless of when reported or paid.

(6) Payments for additional services rendered outside of normal working hours, whether paid in a lump sum or otherwise.

(7) Any employer-provided allowance, reimbursement, or payment, including, but not limited to, one made for housing, vehicle, or uniforms.

(8) Compensation for overtime work, other than as defined in Section 207(k) of Title 29 of the United States Code.

(9) Employer contributions to deferred compensation or defined contribution.

(10) Any bonus paid in addition to the compensation described in subdivision (a).

(11) Any other form of compensation a public retirement board determines is inconsistent with the requirements of subdivision (a).

(12) Any other form of compensation a public retirement board determines should not be pensionable compensation.

ITEMS OF COMPENSATION

1. <u>Pension Savings Plan, Back Award – Item No. OP104 (New)</u>

A new pay code for a one-time ad-hoc cash payment to make whole an employee who is reinstated (due to overturned discharge, suspension or demotion) as part of a corrective contribution to the Pension Savings Plan in

instances where a portion of that corrective contribution cannot be made to the Pension Savings Plan due to Internal Revenue Code contribution limits. The part of the one-time, ad hoc corrective contribution that exceeds those limits will be paid in cash.

This payment should be excluded for legacy members as it is an ad-hoc payment made to some members but not to all similarly situated members.

This payment should also be excluded for PEPRA members as it is an ad hoc payment not found on a public pay schedule.

Recommendation: Exclude under 31461(b)(3)
Exclude under 7522.34

2. Pension Savings Plan Errors and Omissions – Item No. OP105 (New)

A new pay code for a one time, ad-hoc cash payment to make an employee whole where elective and/or non-elective deferrals that should have been made to the Pension Savings Plan were missed due to operational or administrative errors or failures, and a portion of the corrective contribution cannot be made to the Pension Savings Plan due to Internal Revenue Code contribution limits. The part of the one-time, ad hoc corrective contribution that exceeds those limits will be paid in cash.

This payment should be excluded for legacy members as it is an ad-hoc payment made to some members but not to all similarly situated members.

This payment should also be excluded for PEPRA members as it is an ad hoc payment not found on a public pay schedule.

Recommendation: Exclude under 31461
Exclude under 7522.34

3. Assessment Appeals Board, Session 3 – Item No. 568A (Revised)

Since 1995, each member of an Assessment Appeals Board was paid regular earnings under Event Type 099 for the first session (Session 1) up to 4 hours.

An additional amount is paid under pay code 568 for each session up to six hours, (Session 2) in any calendar day. (See Exhibit A for background information).

This new, but related pay item, compensates board members who exceed six hours in any calendar day. The revised definition, County Code Section 6.44.020(B), clarifies that Session 3 consists of a period of more than six hours but not exceeding eight hours.

As this Session falls within normal working hours, it is included for legacy members. It is excluded for PEPRA members as an ad hoc payment dependent on attendance requirements, and not found on a public pay schedule.

Recommendation: Include under 31461
Exclude under 7522.34

4. Field Assignment Bonus – Item No. 630 (Revised)

This pay code is being revised to expand payment eligibility to additional bargaining units within the Department of Mental Health. This additional compensation is in recognition of the need to recruit new staff to provide critical outpatient and crisis intervention services. Each eligible employee is eligible for $180 per month while the employee continues to perform the significant functions of the assignment. Nothing else has changed in the nature of the compensation. Thus, the recommendation remains to include this compensation for legacy members as it is payable to all similarly situated members, but to exclude this compensation for PEPRA members as it is in addition to the normal rate of pay.

Recommendation: Include under 31461
Exclude under 7522.34

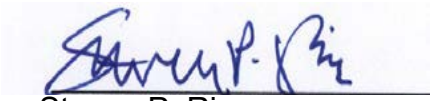
CONCLUSION

Consistent with the foregoing, the attached Resolutions of the Board of Retirement specifying pay items as "Compensation Earnable" under Government Code section 31461 and “Pensionable Compensation” under Government Code section 7522.34 are submitted for approval by the Board.

IT IS THEREFORE RECOMMENDED THAT THE BOARD:

1. Adopt the attached Resolutions, No. 2023-BR001, and No. 2023-BR002, specifying pay items as included and excluded from the definitions of "compensation earnable" and “pensionable compensation.”
2. Instruct staff to coordinate with the County of Los Angeles to establish necessary reporting mechanism and procedures to permit LACERA to include or exclude these items when calculating final compensation.

Reviewed and Approved



Steven P. Rice
Chief Counsel

FMB/et
Attachments

Billingy/BOR/Comp Earn Pen Comp 12.19.22

Exhibit A

Attachment: Newly Created or Newly Revised Codes
reviewed under Section 31461 and 7522.34

Event	Description	Earnings Code Description	31461 Reference	7522.34 Reference	Analysis
Newly Created and EXCLUDED under Section 31461 and 7522.34					
OP104	BACK AWARDS AND JUDGMENTS - PENSION SAVINGS PLAN EXCESS OF LIMIT - GROSS UP AMOUNT (NEW)	To make a Pension Savings Plan (PSP) Participant whole after being granted a back/settlement award, the County may make a corrective contribution toward the PSP Plan for the back pay. The corrective contribution for back pay is subject to the IRS limit in place during the year that contribution is actually paid. If the corrective contribution exceeds the current year's IRS limit, Code OP104 is used to make a one-time, ad hoc cash payment to the employee for that portion of PSP corrective contribution that exceeds the current year's IRS limit. The amount must be grossed up of applicable supplemental payroll tax rates.	(b)(1)(A) (b)(1)(B)	(c)(2) (c)(3) (c)(9) (c)(11)	This payment constitutes compensation that had previously been provided in kind to the member by the employer or paid directly by the employer to a third party other than the retirement system for the benefit of the member and which was converted to and received by the member in the form of a cash payment under Section 31461 (b)(1)(A). It is a one-time or ad hoc payment made to a member, but not to all similarly situated members in the member's grade or class under subdivision (b)(1)(B). The recommendation is to EXCLUDE this payment from compensation earnable for LEGACY members. This payment constitutes compensation that had previously been provided in kind to the member by the employer or paid directly by the employer to a third party other than the retirement system for the benefit of the member and which was converted to and received by the member in the form of a cash payment under Section 7522.34 (c)(2). It is a one-time or ad hoc payment made to a member under subdivision (c)(3). It constitutes employer contributions to deferred compensation or defined contribution plans under subdivision (c)(9). It is a form of compensation that is inconsistent with the requirements of subdivision (a) under (c)(11). The recommendation is to EXCLUDE this payment from pensionable compensation for PEPRA members.
OP105	ERRORS AND OMISSIONS - PENSION SAVINGS PLAN EXCESS OF LIMIT - GROSS UP AMOUNT (NEW)	This code was created to pay the Pension Savings Plan (PSP) corrective contribution related to errors and omissions that exceeds the current year's IRS deferred plan limit. The amount must be grossed up of applicable supplemental payroll tax rates. The corrective contribution is subject to the IRS limit in place during the year that contribution is actually paid. If the corrective contribution exceeds the current year's IRS limit, Code OP105 is used to make a one-time, ad hoc cash payment to the employee for that portion of PSP corrective contribution that exceeds the current year's IRS limit.	(b)(1)(A) (b)(1)(B)	(c)(2) (c)(3) (c)(9) (c)(11)	This payment constitutes compensation that had previously been provided in kind to the member by the employer or paid directly by the employer to a third party other than the retirement system for the benefit of the member and which was converted to and received by the member in the form of a cash payment under Section 31461 (b)(1)(A). It is a one-time or ad hoc payment made to a member, but not to all similarly situated members in the member's grade or class under subdivision (b)(1)(B). The recommendation is to EXCLUDE this payment from compensation earnable for LEGACY members. This payment constitutes compensation that had previously been provided in kind to the member by the employer or paid directly by the employer to a third party other than the retirement system for the benefit of the member and which was converted to and received by the member in the form of a cash payment under Section 7522.34 (c)(2). It is a one-time or ad hoc payment made to a member under subdivision (c)(3). It constitutes employer contributions to deferred compensation or defined contribution plans under subdivision (c)(9). It is a form of compensation that is inconsistent with the requirements of subdivision (a) under (c)(11). The recommendation is to EXCLUDE this payment from pensionable compensation for PEPRA members.

Attachment: Newly Created or Newly Revised Codes
reviewed under Section 31461 and 7522.34

Event	Description	Earnings Code Description	31461 Reference	7522.34 Reference	Analysis
Newly Revised and INCLUDED under Section 31461 and EXCLUDED under 7522.34					
568	**ASSESSMENT APPEALS 2ND SESSION PAY (REVISED)**	This pay code is being revised due to an update to County Code Section 6.44.020 that increased the rate/stipend for the Member Assessment Appeals Board and amended the definitions for each session. The stipend has not changed since it was first established in 1995. Prior to the update, each member of an Assessment Appeals Board was paid an additional $75 under Event Type 568 for attending a full day's session (Session 2) of the board. County Code Section 6.44.020(A) has increased the rate to $123 for Session 2. County Code Section 6.44.020(B) was revised to clarify that Session 2 consisted of a time period of more than four hours but not exceeding six hours in any calendar day.	(a)	(c)(3) (c)(10)	This bonus constitutes remuneration for time worked by persons in the same grade or class of positions during the period, and at the same rate of pay. All Assessment Appeals Board members are entitled to this bonus if they satisfy the attendance requirements. The recommendation is to INCLUDE this bonus in compensation earnable for LEGACY members. This bonus constitutes an ad hoc payment under Section 7522.34 (c)(3). Bonus entitlement is contingent upon meeting attendance requirements. The bonus is paid in addition to the normal rate of base pay under (c)(10). The recommendation is to EXCLUDE this bonus from pensionable compensation for PEPRA members.
568A	**ASSESSMENT APPEALS 3RD SESSION PAY (REVISED)**	This pay code is being revised due to an update to County Code Section 6.44.020 that increased the rate/stipend for the Member Assessment Appeals Board and amended the definitions for each session. Prior to the update, each member of an Assessment Appeals Board was paid an additional $75 for attending a session of the board that exceeded a full day (Session 3) in any calendar day. County Code Section 6.44.020(A) has increased the rate to $124 for Session 3. County Code Section 6.44.020(B) was revised to clarify that Session 3 consisted of a time period of more than six hours but not exceeding eight hours in any calendar day. Prior to this amendment, a full day was capped at six hours.	(a)	(c)(3) (c)(10)	This bonus constitutes remuneration for time worked by persons in the same grade or class of positions during the period, and at the same rate of pay. All Assessment Appeals Board members are entitled to this bonus if they satisfy the attendance requirements. County Code Section 6.44.020(B) no longer caps a full day at six hours. Therefore, Session 3 falls within the full day under the revised definitions. The recommendation is to INCLUDE this bonus in compensation earnable for LEGACY members. This bonus constitutes an ad hoc payment under Section 7522.34 (c)(3). Bonus entitlement is contingent upon meeting attendance requirements. The bonus is paid in addition to the normal rate of base pay under (c)(10). The recommendation is to EXCLUDE this bonus from pensionable compensation for PEPRA members.

Attachment: Newly Created or Newly Revised Codes
reviewed under Section 31461 and 7522.34

Event	Description	Earnings Code Description	31461 Reference	7522.34 Reference	Analysis
Newly Revised and INCLUDED under Section 31461 and EXCLUDED under 7522.34					
630	**FIELD ASSIGNMENT BONUS (REVISED)**	This pay code is being revised to expand payment eligibility to Department of Mental Health (DMH) items that cover a variety of Field Assignments. Prior to this revision, only DMH items permanently paired with Law Enforcement were paid this bonus. A description change for Event Type 630 from "Law Enforcement Service Pay" to "Field Assignment Bonus (FAB)" will be implemented by the Auditor-Controller as a result of the expanded usage to other classifications. This pay code is being expanded to include additional bargaining units for DMH employees in field-based positions that provide critical mental health services. There is a recognized need to retain DMH mental health staff and to vigorously recruit new staff, so that DMH can continue its planned expansion of field-based teams to provide critical outpatient and crisis intervention services. To improve recruitment and retention of these field-based positions and in response to the increased demand for mental health professionals resulting from the pandemic, this bonus was expanded to additional DMH classifications as a financial incentive. Effective July 1, 2022, eligible DMH employees permanently assigned to one of the Field-Based Programs listed below and holding one of the eligible item numbers shall be entitled to a $180 per month (or $90 per pay period) Field Assignment Bonus (FAB). The bonus shall be paid for as long as the employee remains in the assignment and continues to perform the significant functions of the assignment. ELIGIBLE PROGRAMS - Assisted Outpatient Treatment (AOT) - Homeless Outreach and Mobile Engagement (HOME) - Psychiatric Mobile Response Team (PMRT) - Full Service Partnership (FSP) Teams - Law Enforcement Teams (LET) - Mental Evaluation Teams (MET) - School Assessment and Response Team (START) - Therapeutic Transportation - Men's and Women's Community Integration Programs - Veteran's Peer Access Network - GENESIS Older Adult Program - Enhanced Care Management ELIGIBLE ITEMS: 5064, 8161, 8162, 8163, 5884, 5276, 5278, 5121, 5280, 8695, 8693, 8712, 8103, 9001, 9002	(a)	(c)(10)	This payment is payable to all similarly situated members of the Department of Mental Health who work in field-based positions under the specified eligible programs. The recommendation is to INCLUDE this bonus in compensation earnable for LEGACY members. This payment constitutes a bonus paid in addition to the normal rate of base pay under Section 7522.34 (c)(10). The recommendation is to EXCLUDE this bonus from pensionable compensation for PEPRA members.

BEFORE THE BOARD OF RETIREMENT
LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

RESOLUTION OF THE BOARD OF RETIREMENT SPECIFYING ITEMS OF REMUNERATION AS "COMPENSATION EARNABLE"	RESOLUTION NO. 2023-BR001

WHEREAS, LACERA calculates retirement allowances based on a member's "final compensation;"

WHEREAS, LACERA is required to include in the calculation of "final compensation" a member's base pay, and certain other items of remuneration, if such remuneration qualifies as "compensation" under Government Code section 31460 and "compensation earnable" under Government Code section 31461;

WHEREAS, on March 4, 1998, the Board of Retirement adopted Resolution No. 98-004 specifying certain items of remuneration payable to employees of the County of Los Angeles which the Board determined qualify as "compensation" under Government Code section 31460 and "compensation earnable" under section 31461.

WHEREAS, on August 4, 1999, the Board of Retirement adopted Resolution No. 99-001 specifying an additional item of remuneration qualifies as "compensation" and "compensation earnable" under Government Code sections 31460 and 31461, respectively.

WHEREAS, the Court's ruling in *Ventura County Deputy Sheriff's Association v. County of Ventura* (1997) 16 Cal. 4th 483 became final on October 1, 1997, and requires LACERA to include in the calculation of retirement allowances various forms of remuneration not formerly included.

WHEREAS, on July 30, 2020, the California Supreme Court filed its decision entitled *Alameda County Deputy Sheriff's Association v. Alameda County Employees Retirement Association* (2020) 9 Cal.5th 1032 ("*Alameda*"). The *Alameda* decision concludes that all

amendments to the definition of compensation earnable in Government Code section 31461, enacted as a result of the PEPRA and related statutory changes to CERL, effective January 1, 2013 are constitutional. The *Alameda* court also determined that CERL retirement boards have no discretion to include items in compensation earnable that section 31461 requires them to exclude.

NOW THEREFORE, BE IT RESOLVED, AS FOLLOWS:

1. The items of remuneration set forth in Attachment 1 qualify as "compensation earnable" as defined in Government Code section 31461, for purposes of calculating a member's retirement allowance.

2. The items of remuneration set forth in Attachment 2 do not qualify as "compensation earnable" as defined in Government Code section 31461, for purposes of calculating a member's retirement allowance.

BOARD OF RETIREMENT,
LOS ANGELES COUNTY EMPLOYEES
RETIREMENT ASSOCIATION

_____
Les Robbins
Chair, Board of Retirement

Approved as to Form:

_____
Steven P. Rice
Chief Counsel

ATTEST:

_____
Alan J. Bernstein
Vice Chair, Board of Retirement

Attachment No. 1
Board of Retirement
Resolution No. 2023-001
December 19, 2022

ITEMS OF COUNTY REMUNERATION WHICH QUALIFY AS "COMPENSATION," AS DEFINED BY GOVERNMENT CODE SECTION 31460, AND/OR "COMPENSATION EARNABLE," AS DEFINED BY GOVERNMENT CODE SECTION 31461.

EARNINGS NO.	**CODE ITEMS**
099	PATROL STATION RETENTION BONUS
232	AGRICULTURAL WEIGHTS & MEASURE (AWM) INSPECTOR ASSIGNMENT BONUS
249	AGRICULTURE INSPECTORS AID ROVER BONUS
252	6TH AND 7TH STEP FINANCIAL SPECIALIST
253	HEALTHCARE FACILITY BONUS
254	FORENSIC ATTENDANT FIELD TRAINING BONUS
255	BEACHES & HARBORS ASSIGNMENT BONUS
259	TRAILS UNIT ASSIGNMENT BONUS
262	UNDERWATER RECOVERY – BEACHES AND HARBORS
262Y3	UNDERWATER RECOVERY – BEACHES AND HARBORS
262Y4	UNDERWATER RECOVERY – BEACHES AND HARBORS
334	CUSTODY ASSISTANT DRILL INSTRUCTOR/CUSTODY TRAINING AND STANDARDS BUREAU
335	CUSTODY ASSISTANT TRAINING OFFICER BONUS
336	PUBLIC RESPONSE DISPATCHER BONUS
341	IN-FLIGHT BONUS
342	HAZARDOUS MATERIALS CALARP
343	HAZARDOUS MATERIALS APSA

344	FIRE PREVENTION ENGINEERING ASSISTANT
346	HAZARDOUS MATERIALS II EMERGENCY OPERATIONS ASSIGNMENT
347	WELLNESS/FITNESS FOR LIFE BONUS – 1%
348	WELLNESS/FITNESS FOR LIFE BONUS – 2%
349	WELLNESS/FITNESS FOR LIFE BONUS
350	“PILOT PAY” – FIRE DEPARTMENT
355	FIREFIGHTER – PARAMEDIC
355Y2	FIREFIGHTER – PARAMEDIC
355Y3	FIREFIGHTER – PARAMEDIC
358	TEMPORARY PROMOTION BONUS
359	LIFEGUARD PARAMEDIC CATALINA BONUS
359Y2	LIFEGUARD PARAMEDIC CATALINA BONUS
362	PARAMEDIC COORDINATOR/EMS CAPTAIN
363	PEER SUPPORT BONUS
364	DECKHAND/BOAT OPERATOR/RESCUE WATERCRAFT BONUS
365	BACHELOR DEGREE BONUS
366	ADVANCED EDUCATIONAL DEGREE BONUS
369	ADVANCED EDUCATION DEGREE BONUS
381	DENTAL PROFESSIONALS BOARD CERTIFICATION BONUS
384	HIGH DESERT HEALTH ASSIGNMENT BONUS
388	SHERIFF DETENTION FACILITY ASSIGNMENT BONUS

389	MENTAL HEALTH PSYCHIATRIST BOARD CERTIFICATION – MORE THAN ONE SPECIALTY
391	COUNTY LIBRARY DIFFICULT TO RECRUIT ASSIGNMENT BONUS
393	OBSTETRICS/LABOR & DELIVERY ASSIGNMENT
394	MEDICAL HUB CLINIC ASSIGNMENT
415	SHERIFF DEPARTMENT ASSIGNMENT TO AERO BUREAU IONICS SHOP
416	SHERIFF DEPARTMENT WATER SYSTEMS BONUS – CHIEF OPERATOR
417	SHERIFF DEPARTMENT WATER SYSTEMS BONUS – SHIFT OPERATOR
418	ISD BONUS ASSIGNMENT – ENERGY MANAGEMENT SYSTEM SECTION (BEAS)
424	ABDMI REGISTRY CERTIFICATION BONUS
425	ABDMI BOARD CERTIFICATION BONUS
426	ASSESSOR REPRESENTATIVE
427	AUDITOR APPRAISER
428	APPRAISER FIELD TRAINER
439	CUSTODY TRAINING OFFICER
445	SPECIAL ENFORCEMENT DETAIL/CANINE SERVICES DETAIL (TACTICAL DUTY)
452	SUPERVISORY BONUS
457	PATROL STATION RETENTION BONUS

463 DRINKING WATER TREATMENT AND DISTRIBUTION

484 GEOTECHNICAL LICENSE BONUS

486 PLANS EXAMINER CERTIFICATION

487 REGISTRATION – LICENSE BONUS

488 BUILDING ENGINEERING INSPECTOR BONUS

497 INSTITUTIONS BONUS

503 UNIFORM ALLOWANCE

504 NIGHT SHIFT DIFFERENTIAL

505 CORONER'S INQUEST REPORTER

506 VEHICLE USE ALLOWANCE

507 CO-GENERATION MAINTENANCE

508 HENNINGER FLATS WATCHMAN

509 FREEZER WORK

510 DEPARTMENT HEAD MERIT

511 BOARD OF SUPERVISORS PERFORMANCE LUMP SUM

512 FIRE SUPPRESSION TRANSPORTATION TRUCK DRIVER

514 BACKHOE OPERATOR

515 WEEKEND BONUS

516 EXPLOSIVES WORK

517 EVENING SHIFT DIFFERENTIAL

518 POWER EQUIPMENT REPAIR, SNOW CONDITIONS

519 ENGINEERING EMPLOYEES, HAZARD PAY

520 HOME CARE COMPENSATION

522 CUSTODIAN ACTING AS WATCHMAN

523 HYDROELECTRIC OPERATIONS

525 CONTRACTING AND PRODUCTIVITY IMPROVEMENT INCENTIVE FOR MANAGERS

528 WEBCOM PRESS OPERATOR

529 POWER EQUIPMENT OPERATOR, FIRE SUPPRESSION

530 RN EXTRA WEEKENDS WORKED

532 ADDITIONAL RESPONSIBILITIES OR EXCEPTIONAL PERFORMANCE

533 POWER SWEEPER OPERATOR IN EMERGENCY CONDITIONS

534 POWER PLANT RELIEF ENGINEER

535 CLINIC PHYSICIAN, FIRST HOUR AND ONE-HALF

536 CONSULTING SPECIALIST, MD, & MENTAL HEALTH CONSULTANT, MD, FIRST AND FIFTH HOURS

538 RN ASSIGNED AS ACTING OR RELIEF CHARGE NURSE

539 RN WEEKEND DIFFERENTIAL

540 RELIEF NURSE HOLIDAY DIFFERENTIAL (HOURLY ITEM)

541 RELIEF NURSE WEEKEND DIFFERENTIAL (HOURLY ITEM)

544 APPRAISERS LAUNDRY AND DRY-CLEANING ALLOWANCE

545 HEAVY DUTY TOW TRUCK DRIVER

546	SLURRY SEAL TRUCK DRIVER
547	COVID APPRECIATION
547HS	HERO PAY - DHS
548	LIFEGUARD PARAMEDIC – HOURLY
550	INCENTIVE AWARDS FOR MEDI-CAL REIMBURSEMENTS, HEALTH SERVICES
551	GROUP INCENTIVE AWARD, TREASURER TAX COLLECTOR
553	PIONEER EXCAVATION, TUNNEL OPERATIONS, FIRE SUPPRESSION, AND SNOW REMOVAL - CONSTRUCTION INSPECTION AND SURVEYING GROUPS
554	PIONEER EXCAVATION, TUNNEL OPERATIONS, FIRE SUPPRESSION, AND SNOW REMOVAL
555	SCAFFOLD OR SWING STAGE, 30 FEET ABOVE GRADE
556	HIGH SCALE AND RIGGING OPERATIONS, GENERAL
557	EVENING SHIFT, MED TECH
558	NIGHT SHIFT, MED TECH
565	PARAMEDIC RECERTIFICATION BONUS
567	DEPUTY SHERIFF RESERVE ANNUAL COMPENSATION
568	ASSESSMENT APPEALS BOARD, SESSION 2
568A	ASSESSMENT APPEALS BOARD, SESSION 3
571	CSW LICENSURE SUPERVISION
572	MOU LUMP SUM BONUS

575	WASTEWATER PLANT RELIEF BONUS
576	“SOLO DAILY” PAY – COURT REPORTERS
577	INTERPRETER HALF DAY BONUS – SUP. CT.
581	SWIM PROFICIENCY BONUS
585	ISA TREE WORKER CERTIFICATION
586	ISA CERTIFIED ARBORIST CREDENTIAL
587	ISA CERTIFIED QUALIFIED TREE RISK ASSESSOR CREDENTIAL
588	ISA MUNICIPAL SPECIALIST CREDENTIAL
589	MENTAL HEALTH SPECIALITY FIELD BASED BONUS
590	CONT EDUCATION/EQUIPMENT ALLOWANCE/TRAINING BONUS
601	LIFEGUARD PARAMEDIC, RELIEF
602	SUPERVISING TRANSPORTATION DEPUTY PERFORMING DISPATCHER DUTIES
603	AUTOMOTIVE SERVICE EXCELLENCE CERTIFICATES
604	RN MOBILE INTENSIVE CARE CERTIFICATION
605	CUSTODIAN FLOOR WAXING BONUS
606	FIRE EQUIPMENT MECHANIC ASSIGNED FIELD REPAIR DUTIES
606A	FIRE EQUIPMENT MECHANIC ASSIGNED FIELD REPAIR DUTIES – ELIGIBILITY INDICATOR
607	SDPO ASSIGNED ACTING DIRECTOR IN A CAMP
608	BILINGUAL BONUS

609 RN ASSIGNED TO EMERGENCY ROOM

610 ANTELOPE VALLEY FIREFIGHTING CREW

611 TREE TRIMMER SUPERVISOR, POWER OPERATIONS

612 SHOOTING BONUS, EXPERT

613 SHOOTING BONUS, DISTINGUISHED EXPERT

614 SHOOTING BONUS, MARKSMAN

615 SHOOTING BONUS, SHARPSHOOTER

616 ANTELOPE VALLEY QUARTERS, ON FIRE CALL

617 CLINIC NURSE ASSIGNED TO PROBATION CAMP

618 TRANSPORTATION BUS DRIVER, SHERIFF

619 CERTIFIED ACCESS SPECIALISTS

620 SAN GABRIEL DAM OPERATOR

621 NURSE RETENTION INCENTIVE

622 ADVANCED APPRAISER CERTIFICATION

623 PROBATION TRANSCRIBER TYPIST PRODUCTION INCENTIVE

624 BILINGUAL ADDITIONAL BONUS, CHILDREN'S SOCIAL WORKERS

625 AGRICULTURE INSPECTORS ASSIGNED TO STANDARDIZATION

626 FIREFIGHTER PARAMEDIC NOT ASSIGNED TO A PARAMEDIC POST

627 DETENTION AND TRANSPORTATION EXTRA SUPERVISION BONUS

628 BILINGUAL BONUS FOR OTHER THAN MONTHLY EMPLOYEES

629 MORTUARY ATTENDANT AT LAC/USC MC

630 FIELD ASSIGNMENT BONUS

632 MENTAL HEALTH WORKERS ASSIGNED TO SHERIFF'S DETENTION FACILITIES

634 SUPERVISING DETENTION SERVICES OFFICER OF THE DAY

635 TRANSPORTATION DEPUTY BUS DRIVER, PROBATION

636 SHERIFF'S STATION COMMANDER EXPENSES

637 PROFESSIONAL DEVELOPMENT EXPENSES

638 PROBATION TELECOM EQUIPMENT BONUS

639 INTERN HOUSING ALLOWANCE LAC/USC MED. CENTER

640 CHILDREN'S SERVICES ERCP RETENTION

641 SHOOTING BONUS, EXPERT – RESERVE

642 SHOOTING BONUS, DISTINGUISHED EXPERT – RESERVE

643 SHOOTING BONUS, MARKSMAN – RESERVE

644 SHOOTING BONUS, SHARPSHOOTER – RESERVE

645 WELDER CERTIFICATION BONUS

646 EMERGENCY ROLLOUT PROGRAM & SHIFT BONUS

647 BILINGUAL ADDITIONAL BONUS, PSYCHIATRIC SOCIAL WORK

648 DEFIBRILLATION AIRWAY BONUS

649	MAMMOGRAPHY BONUS
650	PRESIDING JUDGE 4% BONUS
653	EQUINE HANDLERS PAY
653	K-9 HANDLERS PAY
694	PARK, TAXABLE
695	TRANSPORTATION ALLOW
696	TRAFFIC MITIGATION
700	“OVERNIGHT TRIP” PAY - SHERIFF’S STATEWIDE UNIT
730	PREMIUM OVERNIGHT TRIP
782	FLSA PREMIUM PAY FOR REGULARLY SCHEDULED WORK ASSIGNMENT
903	NON-ELECTIVE LEAVE BUYBACK
910	SICK BUYBACK
911	VACATION BUYBACK
912	HOLIDAY BUYBACK
913	SICK PRE-71 BUYBACK
914	SICK BUYBACK –PROBATION 56 – HOUR
915	VACATION BUYBACK - 56 HOUR
930	SPECIAL PAID LEAVE BUYBACK
931	APPRAISERS LEAVE BUYBACK
932	INTERN/RESIDENT LEAVE BUYBACK
PP046	EMPLOYEE SUGGESTION

NONE	PARK, NONTAXABLE
NONE	PRIOR SALARY
NONE	56 HOUR TO 40 HOUR ASSIGNMENT BONUS
NONE	REGISTERED NURSE ASSIGNED TO CRITICAL CARE UNIT
TBD	CIVIC CENTER STIPEND

Attachment No. 2
Board of Retirement
Resolution No. 2023-001
December 19, 2022

ITEMS OF COUNTY REMUNERATION WHICH DO NOT QUALIFY AS "COMPENSATION," AS DEFINED BY GOVERNMENT CODE SECTION 31460, AND/OR "COMPENSATION EARNABLE," AS DEFINED BY GOVERNMENT CODE SECTION 31461.

EARNINGS NO.	CODE ITEMS
036	ESP SEVERANCE
075	UNION HALL HIRING VACATION/HOLIDAY BENEFIT
076	FAMILY LEAVE
090	ENHANCED VOLUNTARY TIME OFF LESS THAN 60 DAYS
091	ENHANCED VOLUNTARY TIME OFF GREATER THAN 60DAYS
094	VACATION IN LIEU OF PAY
095	ENHANCED VOLUNTARY TIME OFF-SUPERIOR COURT
128	MILEAGE EARNINGS
129	PARKING
130	SHORT TERM DISABILITY – 60%
131	SHORT-TERM DISABILITY – 40%
140	SHORT TERM DISABILITY – 60% RDO
141	SHORT TERM DISABILITY – 40% RDO
151	INDUSTRIAL ACCIDENT – 100%
152	INDUSTRIAL ACCIDENT – 100% RDO
153	INDUSTRIAL ACCIDENT – 70%
154	INDUSTRIAL ACCIDENT – 70% RDO

158	LIMITED DUTY INDUSTRIAL ACCIDENT – 100%
159	LIMITED DUTY INDUSTRIAL ACCIDENTS – 70%
388	PSYCHIATRY JAIL BONUS
407	NEW HIRE BONUS
500	RELOCATE NON-TAXABLE
502	RELOCATION ALLOWANCE
521	IRS PENALTY REIMBURSEMENT
524	ON-CALL FOR COURT APPEARANCE
527	RELIEF DAM OPERATOR, ON CALL
531	STANDBY
531SP	STANDBY AUTH FOR SHERIFF & PUBLIC WORKS DEPTS ONLYBU 411/412
542	EMERGENCY WORKPLACE DIFFERENTIAL
543	CALL BACK EXTRA COMPENSATION
547	COVID – 19 APPRECIATION PAYMENT
552	STANDBY – EMERGENCY ROLL OUT PROGRAM
559	MISCELLANEOUS LUMP SUM INCLUDED IN REG. OT
560	RECRUITMENT INCENTIVE PROGRAM
561	HOURS PAID BUT NOT WORKED, CALL-BACK
562	MENTAL HEALTH ALERT & PSYCH MOB RESP TEAMSTANDBY
563	RELIEF DAM OPERATIONS STAND-BY

564	TUITION REIMBURSEMENT
566	QUALIFIED FOR HAZARDOUS MATERIALS OVERTIME CALC.
569	PHYSICIANS LOAN REPAYMENT PROGRAM
570	HOME CARE PROGRAM STANDBY
574	STANDBY – INS WITNESS PROGRAM
590	CONT EDUCATION/EQUIPMENT ALLOWANCE/TRAINING BONUS
591	LICENSE REIMBURSEMENT
650	PRESIDING JUDGE 4% BONUS
651	MEAL REIMBURSEMENT – RESIDENTS
652	MEAL REIMBURSEMENT – PLANT ENGINEERS
690	CELLULAR PHONE STIPEND – VOICEMAIL
691	CELLULAR PHONE STIPEND – DATA ONLY
692	CELLULAR PHONE STIPEND – VOICE AND DATA
699W	FLEXIBLE WORK TIME EARNED
701	PAID OVERTIME
702	PAID OVERTIME – ACCRUE FLSA PREMIUM
703	FLSA COMP TIME EARNED-ACCRUE FLSA PREMIUM
705	COMPENSATORY TIME EARNED
707	FY93 COMPENSATORY TIME EARNED
708	FY93 FLSA COMP TIME EARNED – ACCRUE FLSA PREMIUM

709 FY93 FLSA COMP TIME EARNED OVRD – ACCRUE FLSA PREMIUM

710 DISASTER RELATED PAID OVERTIME

711 DISASTER COMP TIME EARNED (ACCRUED)

712 CONTRACT RELATED PAID OVERTIME

713 ER PHYSICIAN OVERTIME – DAY RATE

714 ER PHYSICIAN OVERTIME – WKDY EVE/WKND HOL DAY

715 ER PHYSICIAN OVERTIME – WKDY NITE/WKND HOL EVENITE

716 GUARANTEED PREMIUM

717 PAID OVERTIME – GUARANTEED ACCRUED FLSAPREMIUM

718 FLSA COMP TIME EARNED – GUARANTEED ACCRUED FLSA PREMIUM

719 FLSA COMP TIME EARNED – GUARANTEED PAID PREMIUM

720 SPECIAL EVENTS OVERTIME

731 PREMIUM OVERTIME – SYSTEM

733 PREMIUM OVERTIME – MANUAL

735 FY93 ACCRUED FLSA PREMIUM OVERTIME (SYSTEM)

736 FY93 ACCRUED FLSA PREMIUM OVERTIME (MANUAL)

746 CALL BACK ACTUAL

747 CALL BACK GUARANTEED

761 STRAIGHT TIME AND ONE-HALF

775 SECONDARY OVERTIME

776	ALTERNATE OVERTIME
777	SECONDARY ASSIGNMENT OVERTIME
778	OVERTIME – FIRE DEPT. 56 HOUR
779	SECONDARY OVERTIME – FIRE DEPT. 56 HOUR
780	WORKDOWN OVERTIME – FIRE DEPT.
781	OVERTIME – FIRE DEPT. 40 HOUR
782	PLATOON/40/HOUR/DISPATCHER SCHED PREMIUM –SYSTEM
783	DISPATCHER BRIEFING TIME
784	40 HOUR CAMP-GUARANTEED PREMIUM
791	ORDERED OVERTIME
792	UNCOMPENSATED BRIEFING TIME
793	COMPENSATED BRIEFING TIME – SYSTEM
794	COMPENSATED BRIEFING TIME – MANUAL
795	FY93 ORDERED FLSA COMP TIME EARN – ACCR FLSA PREMIUM
796	ORDERED FLSA COMP TIME EARN-ACCR FLSA PREMIUM
799	FLEX REG HOURS BETWEEN 181 AND 192 FOR 40HR FIRE FIGHTERS
901	COMPENSATORY TIME BUYBACK
902	PROTECTED COMPENSATORY TIME BUYBACK
904	ELECTIVE-LEAVE BUYBACK
905	FLSA COMP TIME BUYBACK – PREMIUM

906 FLSA COMP TIME BUYBACK – STRAIGHT

907 FY93 COMPENSATORY TIME BUYBACK

908 FY93 FLSA COMP TIME BUYBACK – PREMIUM

909 FY93 FLSA COMP TIME BUYBACK – STRAIGHT

916 VACATION IN LIEU OF PAY – BUYBACK

917 DISASTER COMP TIME BUYBACK

918 FY93-56 HOUR COMP TIME BUYBACK – FIRE DEPT.

919 ACCRUED PREMIUM BUYBACK – SYSTEM

920 FY93 FLSA COMP TIME BUYBACK – PREMIUM (MANUAL)

951 ESP VACATION PAYOUT

952 FINAL PAY LEAVE PAYOUT (SICK, HOLIDAY, OT)

953 ESP LEAVE PAYOUT

954 VACATION PAYOUT

955 VACATION IN LIEU OF PAY – PAYOUT

957 56-HOUR LEAVE PAYOUT

958 56-HOUR TC VACATION

961 ESP DEFERRED VACATION PAYOUT

962 DEFERRED LEAVE PAYOUT

963 ESP DEFERRED LEAVE PAYOUT

964 DEFERRED VACATION PAYOUT

967	56-HOUR DEFERRED LEAVE PAYOUT
968	56-HOUR DEFERRED VACATION PAYOUT
970	FLSA PREMIUM COMPENSATORY TIME – PAYOUT
971	FY93 COMP TIME PAYOUT (EXCLUDING PREMIUMS)
OP005	PENSIONABLE STANDBY PAY
OP100	CORRECTIVE PAYMENT, REINSTATED EMPLOYEE – HORIZONS PLAN
OP101	CORRECTIVE PAYMENT, ADMINISTRATIVE ERROR – HORIZONS PLAN
OP102	CORRECTIVE PAYMENT, REINSTATED EMPLOYEE – SAVINGS PLAN
OP103	CORRECTIVE PAYMENT, ADMINISTATIVE ERROR – SAVINGS PLAN
OP104	PENSION SAVINGS PLAN, BACK AWARD
OP105	PENSION SAVINGS PLAN ERRORS AND OMISSIONS
PA099	ROUNDING ADJUSTMENT
PE803	EXCESS STRAIGHT – FLSA COMP TIME TAKEN
PE804	EXCESS PREMIUM – FLSA COMP TIME TAKEN
PE806	EXCESS STRAIGHT – FY93 FLSA COMP TIME TAKEN
PE807	EXCESS PREMIUM – FY93 FLSA COMP TIME TAKEN
PE813	CAPE – EXCESS STRAIGHT – FY93 FLSA COMP TIMETAKEN
PE814	CAPE - EXCESS PREMIUM – FY93 FLSA COMP TIME TAKEN
PFA36	FLEX EARNINGS ADVANCE

PK094 VACATION IN LIEU OF PAY

PK096 SUPERIOR COURT VACATION IN LIEU OF PAY

PK801 COMPENSATORY TIME TAKEN

PK802 PROTECTED COMPENSATORY TIME TAKEN

PK803 FLSA COMP TIME TAKEN – STRAIGHT

PK804 FLSA COMP TIME TAKEN – PREMIUM

PK805 FY93 COMPENSATORY TIME TAKEN

PK806 FY93 FLSA COMP TIME TAKEN – STRAIGHT

PK807 FY93 FLSA COMP TIME TAKEN – PREMIUM

PK808 DISASTER COMP TIME TAKEN

PK810 CALL BACK ACCRUE – STRAIGHT TAKEN

PK811 CALL BACK GUARANTEED CTO – BUY BACK

PK812 DFR 1 YR - NON-FLSA COMPENSATORY STRT TIME –USAGE

PK813 CAPE-FY93 FLSA COMP TIME TAKEN – STRAIGHT

PK814 CAPE-FY93 FLSA COMP TIME TAKEN – PREMIUM

PK815 DFR 1 YR – FLSA COMPENSATORY STRT TIME – USAGE

PK816 DFR 2 YRS – FLSA COMPENSATORY STRT TIME – USAGE

PK818 DFR 1 YR – FLSA PREMIUM OVERTIME USAGE

PK819 DFR 2 YR – FLSA PREMIUM OVERTIME USAGE

PK821 DFR 1 YR – CALL BACK - STRAIGHT USAGE

PKN03	SUPERIOR COURT NON-PENSIONABLE NON-ELECTIVE LEAVE BUY BACK
PKN21	SUPERIOR COURT NON-PENSIONABLE VACATION LEAVE BUY BACK
PO002	ELECTIVE LEAVE TERM PAY OFFSET
PO699	FLEXIBLE WORK SCHEDULE
PO703	STRAIGHT PAY OFFSET – FLSA COMP TIME EARNED – ACCRUE
PO705	STRAIGHT PAY OFFSET – COMPENSATORY TIME EARNED
PO711	STRAIGHT PAY OFFSET – DISASTER COMP TIME EARNEDACC
PO796	STRAIGHT PAY OFFSET – ORDERD FLSA COMP TM EARN –ACCR
PP005	STANDBY PAY - PENSIONABLE
PT002	ELECTIVE LEAVE
PT003	NON-ELECTIVE LEAVE
PT006	DONATED SICK 100% LEAVE – USAGE
PT008	SICK LEAVE EARNED AT MTA/ATTORNEY
PT011	SICK – 100%
PT012	HOLIDAY
PT021	VACATION
PT030	SPECIAL PAID LEAVE
PT031	APPRAISERS LEAVE
PT032	INTERN/RESIDENT LEAVE
PT046	JUDICIAL ASSISTANT SPECIAL PAID LEAVE

PT081 BANK HOLIDAY

PT082 BANK VACATION

PT094 VACATION IN LIEU OF PAY

PT096 SUPERIOR COURT VACATION IN LIEU OF PAY

PT099 REGULAR EARNINGS – MID PAY PERIOD TERMINATION

PT113 SICK PRE-71

PT699 FLEXIBLE WORK TIME EARNED

PT801 COMPENSATORY TIME TAKEN

PT802 PROTECTED COMPENSATORY TIME TAKEN

PT803 FLSA COMP TIME TAKEN – STRAIGHT

PT804 FLSA COMP TIME TAKEN – PREMIUM

PT805 FY93 COMPENSATORY TIME TAKEN

PT806 FY93 FLSA COMP TIME TAKEN – STRAIGHT

PT807 FY93 FLSA COMP TIME TAKEN – PREMIUM

PT808 DISASTER COMP TIME TAKEN

PT810 CALL BACK ACCRUE - STRAIGHT TAKEN

PT811 CALL BACK GUARANTEED CTO – TERMINATION

PT812 DFR 1 YR – NON-FLSA COMPENSATORY STRT TIME – USAGE

PT813 CAPE – FY93 FLSA COMP TIME TAKEN – STRAIGHT

PT814 CAPE – FY93 FLSA COMP TIME TAKEN – PREMIUM

PT815	DFR 1 YR – FLSA COMPENSATORY STRT TIME – USAGE
PT816	DFR 2 YRS – FLSA COMPENSATORY STRT TIME – USAGE
PT817	YTD – FLSA PREMIUM OVERTIME USAGE
PT818	DFR 1 YR – FLSA PREMIUM OVERTIME USAGE
PT819	DFR 2 YR – FLSA PREMIUM OVERTIME USAGE
PT820	YTD – CALL BACK – STRAIGHT USAGE
PT821	DFR 1 YR – CALL BACK – STRAIGHT USAGE
PTNHT	HOLD CURRENT ACCRL – NON-ELECTIVE LEAVE – TERMINATION USAGE
PTVAT	SUPERIOR COURT, RESERVE VACATION – TERMINATION USAGE
PTVPT	SUPERIOR COURT, PRIOR YR RSRV VACATION – TERMINATION USAGE
RP005	PENSIONABLE STANDBY PAY – OFFSET
NONE	MEGAFLEX INDUSTRIAL ACCIDENT
NONE	COUNTY CAR (IMPUTED INC)
NONE	IMPUTED INCOME (DOMESTIC PARTNER)
NONE	IMPUTED INC (LIFE INSURANCE)
NONE	SECTION 170 OVERTIME
NONE	EARNED SALARY ADVANCE
NONE	VACATION PAY ADVANCE
NONE	56 HOUR OVERTIME
NONE	ADJUSTMENT NON-TAX

NONE	RETRO PAY
NONE	EARNED INCOME CREDIT
NONE	UNDERPAYMENT ADVANCE
NONE	O/S SICK PAY
NONE	RETRO ADVANCE
NONE	T/A MILEAGE
NONE	ADVANCED DISABILITY RETIREMENT
NONE	STD REFUND
NONE	LTD REFUND
NONE	LTDH REFUND
NONE	SIB REFUND
NONE	56 VILOP PAY
NONE	VOLUNTARY DEFERRED PAY
NONE	RETRO FLEX BASE
NONE	NR DEFERRED PAY
NONE	F.MF DEFERRED PAY
NONE	DEF LUMP SUM
NONE	DEFERRED PAY
NONE	VOLUNTARY SEPARATION PLAN
NONE	STOP PAYMENT

NONE	FIRE SUPPRESSION CAMP ASSIGNMENT – PREMIUM
NONE	FIRE SUPPRESSION CAMP ASSIGNMENT – COMPENSATORY TIME EARNED
TBD	ANTELOPE VALLEY STIPEND

BEFORE THE BOARD OF RETIREMENT
LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

RESOLUTION OF THE BOARD OF RETIREMENT SPECIFYING ITEMS OF REMUNERATION AS "PENSIONABLE COMPENSATION"	RESOLUTION NO. 2023-BR002

WHEREAS, Government Code section 7522.34 governs the determination of pensionable compensation for those members who became active members for the first time on or after January 1, 2013, who are subject to the California Public Employees' Pension Reform Act of 2013; and

WHEREAS, LACERA calculates retirement allowances based on a member's final compensation; and

WHEREAS, LACERA is required to include in the calculation of "final compensation," a member's base pay and certain other items of compensation, if such compensation qualifies as "pensionable compensation" under Government Code section 7522.34; and

WHEREAS, Government Code section 7522.34 defines "pensionable compensation" as: ". . .the normal monthly rate of pay or base pay of the member paid in cash to similarly situated members of the same group or class of employment for services rendered on a full-time basis during normal working hours, pursuant to publicly available pay schedules"; and

WHEREAS, the Board has analyzed each current pay item and determined whether or not those items should be included in "pensionable compensation"; and

WHEREAS, the Board may find it necessary from time to time to amend its determinations based on changes made by employers, the Legislature, or the Courts;

NOW THEREFORE, BE IT RESOLVED, AS FOLLOWS:

1. For purposes of calculating a member's retirement allowance, earnings on or after January 1, 2013, for members subject to Government Code section 7522.32, as set forth in Attachment No. 1 do not qualify as "pensionable compensation" as defined in section 7522.34.

BOARD OF RETIREMENT,
LOS ANGELES COUNTY EMPLOYEES
RETIREMENT ASSOCIATION

_____
Les Robbins
Chair, Board of Retirement

Approved as to Form:

_____
Steven P. Rice
Chief Counsel

ATTEST:

_____
Alan J. Bernstein
Vice Chair, Board of Retirement

Attachment No. 1
Board of Retirement
Resolution No. 2023-002
December 19, 2022

ITEMS OF REMUNERATION EARNED ON OR AFTER JANUARY 1, 2013, FOR MEMBERS SUBJECT TO GOVERNMENT CODE SECTION 7522.32, WHICH DO NOT QUALIFY AS "PENSIONABLE COMPENSATION" AS DEFINED IN SECTION 7522.34.

EARNINGS NO.	**CODE ITEMS**
200	76-INCH MOWER BONUS
201	ACTING DEPARTMENT HEAD
202	ACTING MEDICAL DIRECTOR
203	ADDITIONAL RESPONSIBILITIES
204	AMERICAN MEDICAL ASSOCIATION BOARD CERT 8.25%
205	AMERICAN MEDICAL ASSOCIATION BOARD CERT 5.50%
209	MANPOWER SHORTAGE RANGE
210	MEDICAL DIRECTOR'S BONUS - 2.75
211	MEDICAL DIRECTOR'S BONUS - 5.50%
212	MEDICAL DIRECTOR'S BONUS - 8.25%
214	OUT OF CLASS BONUS
215	POST BONUS - ADVANCE/EXECUTIVE
217	POST BONUS – INTERMEDIATE
219	SUPERIOR SUBORDINATE PAY
220	WATCHMAN – CUSTODIAN
221	WELFARE RECIPIENT SUPERVISOR
222	OUT OF CLASS BONUS SCHEDULE/LEVEL/PERCENT
223	TEMPORARY CLERICAL & OFFICE SERVICES EMPLOYEES

224 PBP NON-BASE MERIT SALARY ADJUSTMENT

225 EXECUTIVE SECRETARY ADDED SALARY SCHEDULES

227 PBP TO SCHEDULE SALARY ADJUSTMENT

228 ADDITIONAL RESPONSIBILITIES – REPRESENTED

229 TEMPORARY SPECIAL MAP ACHIEVEMENT – FLAT

230 TEMPORARY SPECIAL MAP ACHIEVEMENT – PERCENT

231 TEMPORARY ASSIGNMENT MAP EMPLOYEE – FLAT

240 AGRICULTURAL INSPECTOR BONUS

243 CAREER DEVELOPMENT INTERN BONUS

248 REGIONAL PLANNING AICP CERTIFICATION BONUS

249 AGRICULTURE INSPECTORS AID ROVER BONUS

250 ACCOUNTING CERTIFICATE

252 6TH AND 7TH STEP FINANCIAL SPECIALIST

254 FORENSIC ATTENDANT FIELD TRAINING BONUS

256 ANIMAL CONTROL MGR-BOARD LIAISON BONUS

257 HALF STEP-01

258 HALF STEP-02

263 AUDITOR-CONTROLLER MERIT - ONE SCHEDULE

264 AUDITOR-CONTROLLER MERIT - TWO SCHEDULES

265 AUDITOR-CONTROLLER MERIT - THREE SCHEDULES

266 AUDITOR-CONTROLLER MERIT - FOUR SCHEDULES

267	AUDITOR-CONTROLLER MERIT - FIVE SCHEDULES
268	AUDITOR-CONTROLLER MERIT - SIX SCHEDULES
270	BOARD OF SUPERVISOR SPECIAL ASSIGNMENT
271	ASSESSMENT APPEALS BOARD ASSIGNMENT
272	HEAD BOARD SPECIALIST ADDITIONAL STEPS
273	MAPP TIER II STEP 13
274	MAPP TIER II STEP 14
275	MAPP TIER II STEP 15
276	MAPP TIER II STEP 16
277	MAPP TIER II STEP 17
278	MAPP TIER II STEP 18
281	MAPP TO SCHEDULE FLAT AMOUNT
282	MAPP TO SCHEDULE PERCENTAGE
283	PERM PHYSICIAN TRANSITION RATE – PERCENT
285	COURT CLERK - GREATER SKILLS
291	INTERGOVERNMENTAL RELATIONS
293	LEGISLATIVE REPRESENTATIVE-CAO
295	MANAGEMENT TRAINEE
300	CURATOR BONUS
310	LEGISLATIVE ADVOCATE – COUNTY COUNSEL
320	ACCOUNTING CERTIFICATE – DA

321 DISTRICT ATTORNEY – OUT OF CLASS BONUS

322 RECLASSIFIED INVESTIGATOR

323 ANTELOPE VALLEY ASSIGN. 30 MILES FROM RESIDENCE

332 JOURNEY EMPLOYEES BONUS

334 CUSTODY ASSISTANT DRILL INSTRUCTOR/CUSTODY TRAINING AND STANDARDS BUREAU

335 CUSTODY ASSISTANT TRAINING OFFICER BONUS

336 PUBLIC RESPONSE DISPATCHER BONUS

338 ELEVATOR ADJUSTOR

340 A OR B MOTOR VEHICLE LICENSE BONUS

342 HAZARDOUS MATERIALS CALARP

343 HAZARDOUS MATERIALS APSA

344 FIRE PREVENTION ENGINEERING ASSISTANT

347 WELLNESS/FITNESS FOR LIFE BONUS – 1%

348 WELLNESS/FITNESS FOR LIFE BONUS – 2%

349 WELLNESS/FITNESS FOR LIFE BONUS

356 FIRE SAFETY PERSONNEL BONUS

357 HELICOPTER INSPECTION LICENSE

358 TEMPORARY PROMOTION BONUS

361 TEMPORARY PROMOTION BONUS - NON-SCHEDULE

365 BACHELOR DEGREE BONUS

366 ADVANCED EDUCATIONAL DEGREE BONUS

367 MEDICAL STAFF CREDENTIALING ASSIGNMENTBONUS

368 RN ASSIGNED TO SHERIFFS DEPT

369 RN ADVANCED EDUCATIONAL DEGREE BONUS

370 CLINIC NURSE - STAND BY

371 CLINICAL INSTRUCTOR - GENERAL

372 CLINICAL INSTRUCTOR - LAC+USC MEDICAL CENTER

373 EMERG MEDICINE - BOARD CERTIFICATION

374 EMERG MEDICINE - BOARD CERT

375 EMERG MEDICINE - BOARD CERTIFICATION 8.25%

376 HIGH DESERT HOSPITAL - PHYSICIAN BONUS

377 JOURNEY EMPLOYEES BONUS

379 SUPERVISING NURSE - ICU

380 SUPVG RAD TECHN - DIAGNOSTIC ULTRASOUND

381 DENTAL PROFESSIONALS BOARD CERTIFICATION BONUS

383 VETERINARY MEDICINE- BOARD CERTIFICATION

384 HIGH DESERT HEALTH ASSIGNMENT BONUS

385 PSYCHIATRY SPECIALTY BONUS

386 PHYSICIAN SPECIALTY BONUS

387 PHARMACIST SPECIALTY ASSIGNMENTS

388 SHERIFF DETENTION FACILITY ASSIGNMENT BONUS

389	MENTAL HEALTH PSYCHIATRIST BOARD CERTIFICATION – MORE THAN ONE SPECIALTY
391	COUNTY LIBRARY DIFFICULT TO RECRUIT ASSIGNMENT BONUS
392	LIBRARIAN BONUS
393	OBSTETRICS/LABOR & DELIVERY ASSIGNMENT
394	MEDICAL HUB CLINIC ASSIGNMENT
395	PHYSICIAN SPECIALTY BONUS - 5.75%
396	PHYSICIAN ADDITIONAL COMPENSATION
397	PHYSICIAN FORENSIC PATHOLOGY BONUS
398	HOSPITAL ADMINISTRATOR - ADDITIONAL COMPENSATION
400	DEPUTY COURT ADMINISTRATOR - OPINION/ADVISOR
401	DEPUTY MARSHALL - LEVEL I BONUS
402	DEPUTY MARSHALL - LEVEL II BONUS
403	DEPUTY MARSHALL TRAINEE
404	ELECTRONIC RECORDING EQUIPMENT
405	MARSHALL SUPERVISING BONUS
406	DEPUTY MARSHAL SPECIAL TRAINING - 6TH STEP
407	NEW HIRE BONUS
408	DEPUTY CLERK III OUT OF CLASS BONUS
409	STENOGRAPHIC SKILLS
410	SUPERVISING DEPUTY CLERK

411 ADVISOR – COURT ADMINISTRATOR AND JUDGES

412 NIGHT SHIFT AND WEEKEND BONUS

413 DEPUTY CLERK IV – GREATER SKILLS

414 RECORDING EQUIPMENT – DEPUTY CLERK IV M.C.

415 SHERIFF DEPARTMENT ASSIGNMENT TO AERO BUREAU AVIONICS SHOP

416 SHERIFF DEPARTMENT WATER SYSTEM BONUS – CHIEF OPERATOR

417 SHERIFF DEPARTMENT WATER SYSTEM BONUS – SHIFT OPERATOR

418 ISD BONUS ASSIGNMENT – ENERGY MANAGEMENT SYSTEM SECTION (SEAS)

424 ABDMI REGISTRY CERTIFICATION BONUS

425 ABDMI BOARD CERTIFICATION BONUS

430 ASST. DIRECTOR – PUBLIC SOCIAL SERVICES

432 DEPUTY DISTRICT DIRECTOR TRAINEE

439 CUSTODY TRAINING OFFICER

441 CATALINA ISLAND LIVING – SHERIFF

445 SPECIAL ENFORCEMENT DETAIL/CANINE SERVICES DETAIL (TACTICAL DUTY)

450 SHERIFF OUT OF CLASS BONUS

453 SERGEANT-AT-ARMS BOARD OF SUPERVISOR

456 TRAINING OFFC/INVESTIGATOR/K-9 BONUS

458 ACTING CAPACITY BONUS

461 SHERIFF BUSINESS MACHINE TECHNICIAN

464 STATE OF CALIF STRUCTURAL ENGINEER LICENSE BONUS

465 REHABILITATION INSPECTOR-PUBLIC WORKS

468 LICENSED LAND SURVEYOR BONUS

469 LICENSED REGISTERED TRAFFIC ENGINEER BONUS

470 BUSINESS LICENSE LIAISON

475 CERTIFICATION BONUS – LACERA

480 SUPERIOR COURT CLERK BONUS

481 COURT REPORTERS REALTIME CERTIFICATION

482 JUDICIAL ASSISTANT BONUS

483 REALTIME WRITING BONUS

484 GEOTECHNICAL LICENSE BONUS

485 SUP CRT EXEC OFFICER ADDITIONAL COMPENSATION

486 PLANS EXAMINER CERTIFICATION REGISTRATION – LICENSE BONUS

488 BUILDING ENGINEERING INSPECTOR BONUS

493 SENIOR PROBATION DIRECTOR-CENTRAL JUVENILE HALL

494 SENIOR PROB DIR-LOS PADRINOS/SAN FERNANDO JUV HALL

495 PROBATION DIRECTOR-ADMIN RESP./FOOTHILL JUV AREA

498 PROBATION DIRECTOR-CHALLENGER YOUTH CENTER

501 BOARD OF RETIREMENT CASE REVIEW

503 UNIFORM ALLOWANCE

504 NIGHT SHIFT DIFFERENTIAL

505 CORONER'S INQUEST REPORTER

506 ALLOWANCE IN LIEU OF VEHICLE USE

507 CO-GENERATION MAINTENANCE

508 HENNINGER FLATS WATCHMAN

509 FREEZER WORK

510 DEPARTMENT HEAD MERIT

511 BOARD OF SUPERVISORS PERFORMANCE LUMP SUM

512 FIRE SUPPRESSION TRANSPORTATION TRUCK DRIVER

513 MOU LUMP SUM BONUS

514 BACKHOE OPERATOR

515 WEEKEND BONUS

516 EXPLOSIVES WORK

517 EVENING SHIFT DIFFERENTIAL

518 POWER EQUIPMENT REPAIR, SNOW CONDITIONS

519 ENGINEERING EMPLOYEES, HAZARD PAY

520 HOME CARE COMPENSATION

522 CUSTODIAN ACTING AS WATCHMAN

523 HYDROELECTRIC OPERATIONS

525 CONTRACTING & PRODUCTIVITY IMPROVE INCNTV FOR MNGR

528	WEBCOM PRESS OPERATOR
529	POWER EQUIPMENT OPERATOR, FIRE SUPPRESSION
531	STANDBY
532	ADDITIONAL RESPONSIBILITIES AND EXCEPTIONAL PERFORMANCE
533	POWER SWEEPER OPERATOR IN EMERGENCY CONDITIONS
534	POWER PLANT RELIEF ENGINEER
535	CLINIC PHYSICIAN FIRST HOUR
536	CONSULTING SPEC, MD & MNTL HEALTH CONSLT, 1st & 5th
538	RN ASSIGNED AS ACTING OR RELIEF CHARGE NURSE
539	RN WEEKEND DIFFERENTIAL
540	RELIEF NURSE HOLIDAY DIFFERENTIAL
541	RELIEF NURSE WEEKEND DIFFERENTIAL
542	EMERGENCY WORKPLACE DIFFERENTIAL
544	APPRAISERS LAUNDRY AND DRY-CLEANING ALLOWANCE
545	HEAVY DUTY TOW TRUCK DRIVER
546	SLURRY SEAL TRUCK_DRIVER
547	COVID APPRECIATION
547HS	HERO PAY – DHS
548	LIFEGUARD PARAMEDIC - RELIEF
550	INCENTIVE AWARDS FOR MEDI-CAL REIMBRMNTS/ HEALTH SR

551	GROUP INCENTIVE AWARD, TREASURER TAX COLLECTOR
552	STANDBY - EMERGENCY ROLL OUT PROGRAM
553	PIONEER EXCAVTN, TUNNEL OPERATNS, FIRE SUPP, SNOW
554	PIONEER EXCAVTN, TUNNEL OPERATNS, FIRE SUPP, SNOW
555	SCAFFOLD OR SWING STAGE, 30 FEET ABOVE GRADE
556	HIGH SCALE AND RIGGING OPERATIONS, GENERAL
557	EVENING SHIFT, MED TECH
558	NIGHT SHIFT, MED TECH
560	PHYSICIAN RECRUITMENT PROGRAM
565	PARAMEDIC RECERTIFICATION BONUS
565A	PARAMEDIC RECERTIFICATION BONUS – ELIGIBILITY INDICATOR
567	DEPUTY SHERIFF RESERVE ANNUAL COMPENSATION
568	ASSESSMENT APPEALS BOARD, SESSION 2
568A	ASSESSMENT APPEALS BOARD, SESSION 3
569	PHYSICIAN LOAN PAYMENT PROGRAM
570	HOME CARE PROGRAM STANDYBY
571	CHILDREN'S SOCIAL WORKERS LICENSURE SUPERVISION
572	MOU LUMP SUM BONUS
574	STANDBY – INS WITNESS PROGRAM
575	WASTEWATER PLANT RELIEF BONUS
576	SOLO DAILY EARNINGS

577 INTERPRETER HALF DAY BONUS - SUP CT

578 ER ATTENDING PHYSICIAN - DAY RATE

579 ER ATTENDING PHY/-WKDY EVE/WKND HOLDAY

580 ER ATTENDING PHY/-WKDY NITE/WKND HOLIDAY EVE NITE

581 SWIM PROFICIENCY BONUS

582 INTERPRETER REGULAR MULTIPLE LANGUAGE SAME DAY

583 INTERPRETER-HOURLY/DAILY MULT LANG SAME DAY

584 PHYSICIAN STIPENDS

585 ISA TREE WORKER CERTIFICATION

586 ISA CERTIFIED ARBORIST CREDENTIAL

587 ISA CERTIFIED QUALIFIED TREE RISK ASSESSOR CREDENTIAL

588 ISA MUNICIPAL SPECIALIST CREDENTIAL

589 MENTAL HEALTH SPECIALITY FIELD BASED BONUS

590 CONT EDUCATION/EQUIPMENT ALLOWANCE/TRAINING BONUS

591 LICENSE REIMBURSEMENT

600 REGISTERED NURSE MOBILE INTENSIVE CARE CERTIFICATION, SUB-ITEM D

602 SUPERVISING TRANSPORTATN DEPTY PERFORMING DISPATCHER DUTIES

603 AUTOMOTIVE SERVICE EXCELLENCE CERTIFICATE

604 REGISTERED NURSE MOBILE INTENSIVE CARE CERTIFICATION

605 CUSTODIAN FLOOR WAXING BONUS

606	FIRE EQUIPMENT MECHANIC ASSIGNED FIELD REPAIR DUTY
606A	FIRE EQUIPMENT MECHANIC ASSIGNED FIELD REPAIR DUTY – ELIGIBILITY INDICATOR
607	SUPERVISING DEPUTY PROBATION OFFICER (SPDO) ASSIGNED ACTING DIRECTOR IN A CAMP
608	BILINGUAL BONUS
609	REGISTERED NURSE ASSIGNED TO EMERGENCY ROOM
610	ANTELOPE VALLEY FIREFIGHTING CREW
611	TREE TRIMMER SUPERVISOR, POWER OPERATIONS
612	SHOOTING BONUS, EXPERT
613	SHOOTING BONUS, DISTINGUISHED EXPERT
614	SHOOTING BONUS, MARKSMAN
615	SHOOTING BONUS, SHARPSHOOTER
616	ANTELOPE VALLEY QUARTERS, ON FIRE CALL
617	CLINIC NURSE ASSIGNED TO PROBATION CAMP
618	TRANSPORTATION BUS DRIVER, SHERIFF
619	CERTIFIED ACCESS SPECIALIST
620	SAN GABRIEL DAM OPERATOR
621	NURSE RETENTION INCENTIVE
622	ADVANCED APPRAISER CERTIFICATION
624	BILINGUAL ADDITIONAL BONUS, CHILDREN'S SOCIAL WORK
625	AGRICULTURE INSPECTORS ASSIGNED TO STANDARDIZATION

627	DETENTION & TRANSPORTATION EXTRA SUPERVISION BONUS
628	BILINGUAL BONUS FOR OTHER THAN MONTHLY
628A	BILINGUAL BONUS FOR OTHER THAN MONTHLY-ELIGIBILITY INDICATOR
629	MORTUARY ATTENDANT AT LAC+USCMC
630	FIELD ASSIGNMENT BONUS
631	BILINGUAL BONUS-SUB D
632	MENTAL HEALTH WORKERS ASSIGND SHERIFF DETENTN FACL
633	RN ASSIGNED TO EMERGENCY ROOM SUB D
634	SUPERVISING DETENTION SERVICES OFFICER OF THE DAY
635	TRANSPORTATION DEPUTY BUS DRIVER, PROBATION
636	INCIDENTAL EXPENSE ALLOWANCE
637	PROFESSIONAL DEVELOPMENT EXPENSES
638	PROBATION TELECOM EQUIPMENT BONUS
640	CHILDRENS SERVICES ERCP RETENTION
641	SHOOTING BONUS, EXPERT – RESERVE
642	SHOOTING BONUS, DISTINGUISHED EXPERT – RESERVE
643	SHOOTING BONUS, MARKSMAN – RESERVE
644	SHOOTING BONUS, SHARPSHOOTER – RESERVE
645	EMERGENCY ROOM BONUS/PAT FIN SVCS WKR/PAT RES WKR
646	EMERGENCY ROLL OUT PROGRAM & SHIFT BONUS

647	BILINGUAL ADDITIONAL BONUS, PSYCH SOCIAL WORK
648	DEFIBRILLATION AIRWAY BONUS
649	MAMMOGRAPHY BONUS
690	CELLULAR PHONE STIPEND – VOICEMAIL
691	CELLULAR PHONE STIPEND - DATA ONLY
692	CELLULAR PHONE STIPEND - VOICE AND DATA
694	CIVIC CENTER COMMUTER ALLOWANCE
695	DEPARTMENT HEAD TRANSPORTATION ALLOWANCE
696	DEPARTMENT HEAD TRAFFIC MITIGATION ALLOWANCE
700	PENSIONABLE OVERTIME
730	PREMIUM OVERTIME - SYSTEM PENSIONABLE
PF004	MEGAFLEX PENSIONABLE CONTRIBUTION
PF007	FLEX PENSIONABLE CONTRIBUTION
PF010	CHOICES PENSIONABLE CONTRIBUTION
PF013	OPTIONS PENSIONABLE CONTRIBUTION
PK003	NON-ELECTIVE LEAVE
PK011	SICK - 100%
PK012	HOLIDAY
PK021	VACATION
PK030	SPECIAL PAID LEAVE
PK031	APPRAISERS LEAVE

PK032	INTERN/RESIDENT LEAVE
PK113	SICK PRE-71
PKN03	SUPERIOR COURT NON-PENSIONABLE NON-ELECTIVE LEAVE BUY BACK
PKN21	SUPERIOR COURT NON-PENSIONABLE VACATION LEAVE BUY BACK
PKP11	SICK LEAVE BUY BACK 100%
PKP21	VACATION BUY BACK
PP046	EMPLOYEE SUGGESTION
NONE	REGISTERED NURSE ASSIGNED TO CRITICAL CARE UNITS
NONE	FIRE SUPPRESSION CAMP ASSIGNMENT – PREMIUM
NONE	FIRE SUPPRESSION CAMP ASSIGNMENT – COMPENSATORY TIME EARNED
NONE	POST, SUPERVISORY BONUS
OP100	CORRECTIVE PAYMENT, REINSTATED EMPLOYEE – HORIZONS PLAN
OP101	CORRECTIVE PAYMENT, ADMINISTRATIVE ERROR – HORIZONS PLAN
OP102	CORRECTIVE PAYMENT, REINSTATED EMPLOYEE – SAVINGS PLAN
OP103	CORRECTIVE PAYMENT, ADMINISTRATIVE ERROR – SAVINGS PLAN
OP104	PENSION SAVINGS PLAN, BACK AWARD
OP105	PENSION SAVINGS PLAN ERRORS AND OMISSIONS
TBD	CIVIC CENTER STIPEND

TBD ANTELOPE VALLEY STIPEND

December 22, 2022

TO: Each Trustee
Board of Retirement

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: January 4, 2023, Board of Retirement Meeting

SUBJECT: **CONSIDER APPLICATIONS FOR LACERA PANEL OF EXAMINING PHYSICIANS**

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Applications listed below be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Frank Boyd, Sr. Staff Counsel and Glenn Ehresmann, M.D., Board Medical Advisor have reviewed the application, medical credentials and license, and sample reports and have agreed that the Application be submitted to the Board of Retirement for consideration for the LACERA Panel of Examining Physicians. Attached for your review is staff's Summary and Recommendation, Panel Physician Application, Curriculum Vitae, and sample reports.

IT IS THEREFORE RECOMMENDED THAT the Board approve the following Applications for the LACERA Panel of Examining Physicians.

OSEP E. ARMAGAN, M.D. – Orthopedic
JESSE CARR, M.D. – Psychiatry
DIVAKAR KRISHNAREDDY, M.D. – Orthopedic
RICHARD C. ROSENBERG, M.D. – Orthopedic
GABOR VARI, M.D. – Psychiatry

Attachments

RC:mb

December 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: January 4, 2023, Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
OSEP E. ARMAGAN, M.D. - ORTHOPEDIC

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Osep Armagan, M.D. be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

Osep Armagan, M.D., is Board Certified in Orthopedic Surgery. He received his medical degree from Medical College of Wisconsin and completed his residency at the University of Illinois and a fellowship Medical College of Pennsylvania and Hahnemann University Sports Medicine. Dr. Armagan has 10 years of experience as an independent medical examiner and 4 years of experience performing medical legal evaluations for both public and private organizations.

Upon approval to the panel, LACERA will conduct a virtual orientation with DRS staff, legal counsel and the physician and his management team to provide a comprehensive overview of the LACERA Panel Physician Guidelines, requirements and protocols to ensure a thorough understanding of the Rules in Evaluating Applicants, Disability Retirement Law Standards, and what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff will also cover report submission timeframes, fee schedule and billing procedures. Additional diagnostic testing request protocols; medical license, Board Certification, and insurance coverage requirements. Lastly, staff will provide an overview of the Quality Control Questionnaire process and procedures.

On December 21, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Osep Armagan, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Osep Armagan, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

/TLC

LACERA Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-6132 • 800/786-6464

APPLICATION TO LACERA PANEL OF EXAMINATION PHYSICIANS

ALL APPLICANTS MUST SUBMIT THE FOLLOWING WITH THEIR APPLICATION

- Current Curriculum Vitae
- Two (2) Sample" Medical Reports – Must be Redacted
- Copy of Medical License
- Copy of Board Certification(s) – Applicant must be board certified to qualify for panel
- Certificate of Insurance

GENERAL INFORMATION Please attach a list of any additional locations.	Date 12/23/2021
Physician Name: Osep E. Armagan, MD	Group Name: Osep E. Armagan, MD Inc.
Primary Address: 50 North La Cienega Blvd., Suite # 215	
Primary Contact: Elaine Jajja	Title: Office manager
Telephone: 310-246-1011 Fax: 310-360-0919	Email: elaine@armaganmd.com
Secondary Address: 110 Jensen Court, Suite # 1 C, Thousand Oaks, CA 91361	
Telephone: 310-246-1011 Fax: 310-360-0919	Email: elaine@armaganmd.com

PHYSICIAN BACKGROUND	
Field of Specialty: Orthopedic Surgery Board Certification ☒Yes ☐No	Subspecialty: Spine, Hand, Trauma, Foot Ankle, Sports Board Certification ☐Yes ☐ No
License # **G88110** Expiration Date: Click or tap here to enter text.	
Has your license been suspended in the last 3 years? ☐Yes ☒No Has there been any disciplinary actions filed against you in the last 3 year? ☒Yes ☒ No	

EXPERIENCE AND CURRENT PRACTICE
Indicate the number of years of experience that you have in each category and the time spent performing each activity.

Type	Number of Years	Current Practice	Time Spent (%)
AME	4	Treatment	50
IME	10	Evaluations	50
QME	4	Research	0
Workers' Compensation Evaluations	4	Teaching	0
Disability Evaluations	4		100 %

Med-Legal Reports	8		

Performing Medical Evaluations for Public Organizations ☒Yes ☐No

Performing Medical Evaluations for Private Organizations ☒Yes ☐No

Please Names of Organizations: Cal Pers, Longshore NY

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

LACERA FEE SCHEDULE	
Physical Exam and Initial Report	$2,015.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Record Review Only and Initial Report	$1,007.50 + Additional Fee for Reviewed Records* (see Review of Record rate)
Psychiatric/Psychological Examination (in office) and Initial Report*	$ 4, 030.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Psychiatric/Psychological Examination (no exam) and Initial Report*	$ 2,015.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Toxicology and Oncology Examination (in office) and Initial Report*	$ 3,022.50 + Additional Fee for Reviewed Records* (see Review of Record rate)
Toxicology and Oncology Examination (no exam) and Initial Report*	$ 1,511.25 + Additional Fee for Reviewed Records* (see Review of Record rate)
*Review of Records (by Physician)	$ 455.00 per inch (LACERA will pay up to 1 hour of record-review per inch of medical records)
*Review of Records (by Nurse)	$ 75.00 per inch (LACERA will pay up to 1 hour of record-review per inch of medical records)
Supplemental Report	$ 455.00 per hour
Supplemental Report when Panel Physician Guidelines were not followed	No charge
Other Fees	
Administrative Hearing Preparation	$ 455.00 per hour
Depositions	$ 455.00 per hour with 2 hours minimum
Expert Witness in Superior or Appellate Court	$3,500 – Half Day
Expert Witness in Superior or Appellate Court	$7,000 – Full Day

Cancellation Policy and Fees
Please indicate your cancellation policy and any applicable fees.

What is you Cancellation Policy? (Attach policy, if applicable).
6 business days, no fee

Cancelled Exams that do not adhere to your stated policy: Fee: $ **650**

Cancelled Hearings that do not adhere to your stated policy: Fee: $ **910**

Name of person completing this form:

Print Name:	Title:
OSEP E. ARMAGAN	M.D.
Physician Signature:	Date
Osep E. Armagan MD	12/23/2021

You may attach additional pages if necessary.

Revised: 12/8/21

CURRICULUM VITAE

Updated 12/2021

OSEP E. ARMAGAN, M.D, QME

ADDRESS 50 North La Cienega Blvd
Suite 215
Beverly Hills, CA 90211
Tel: 310-246-1011
Fax: 310-360-0919
Email: oseparmagan@ymail.com

PERSONAL Birth Date: [redacted]
Birth Place: [redacted]
Marital Status: [redacted]

PROFESSIONAL PRACTICE

Osep E. Armagan, MD, QME
50 North La Cienega Blvd
Suite # 215
Beverly Hills, CA 90211
Tel: 310-246-1011
Fax: 310-360-0919
March 1, 2019

Osep E. Armagan MD, Inc
110 Jensen Court
Suite 1 C
Thousand Oaks, CA 91360
Tel: 818-657-5645
Fax: 424-293-8647
January 1, 2015 - present

Regal Medical Group
3605 Alamo Street
Suite # 100
Simi Valley, CA 93063
Tel: 805-210-7280
Fax: 805-522-7454
Aug 2011 – Dec 2014

Osep Armagan MD, Inc
3695 Alamo Street,
Suite # 100
Simi Valley, CA 93063
Tel: 818-254-1500
Fax: 818-291-4058
May 2009 – Aug 2011

Simi Orthopedics and Sports Medicine
2750 North Sycamore Drive, Suite # 210
Simi Valley, CA 93065
Tel: 805-520-2663
Fax: 805-520-5950
August 1, 2008 – April 30, 2009

Wheaton Franciscan Healthcare
All Saints St. Mary's Hospital
3811 Spring Street
Racine, Wisconsin 53405
Tel: (262) 687-5880
Fax: (262) 687-5895
July 2001 – May 2008

Glen Ellyn Clinic
454 Pennsylvania Avenue
Glen Ellyn, Illinois 60137
Tel: (630) 790-1872
Fax: (630) 545-7850
August 1, 2000 – June 2001

University of Illinois at Chicago
Clinical Assistant Professor
Foot and Ankle Surgery, Sports Medicine
Department of Orthopaedic Surgery
Tel: 312-996-7161
September 1999 – May 2008

Woodfield Orthopaedics and
Sports Medicine Ltd.
Martin L. Saltzman, MD
375 South Roselle Road
Schaumburg, Illinois 60193
Tel: (847) 301-7773
Fax: (847) 301-6506
August 1998 – July 2000

HOSPITAL AFFILIATIONS

Glendale Adventist Medical Center
1509 Wilson Terrace
Glendale, CA 91206
Tel: (818) 409-8000
June 10, 2010 – present

Los Robles Hospital and Medical Center
215 West Janss Road
Thousand Oaks, CA 91360
Tel: (805) 370- 4553
May 2011 – present

EDUCATION

FELLOWSHIP (2)
Medical College of Wisconsin
Department of Orthopaedic Surgery
Foot and Ankle Surgery
Michael J. Shereff, M.D.
8700 West Wisconsin Avenue
Milwaukee, Wisconsin 53226
(414) 257-6655
August 1, 1997 – July 31, 1998

Medical College of Pennsylvania and
Hahnemann University Sports Medicine,
Arthroscopic and Reconstructive Knee and
Shoulder Surgery Fellowship
Joseph S. Torg, M.D.
Brian J. Sennett, M.D.
219 North Broad Street, 3rd Floor
Philadelphia, Pennsylvania 19107
(215) 762-5196
Fax: (215) 762-5150
August 1, 1996 – July 31, 1997

ORTHOPAEDIC SURGERY
University of Illinois at Chicago
College of Medicine
Riad Barmada, M.D. Chairman
Department of Orthopaedics (M/C 844)
209 Medical Sciences South
901 South Wolcott Avenue
Chicago, Illinois 60612-7342
(312) 996-7161
July 1, 1992 – June 30, 1996

INTERNSHIP
General Surgery Rotating Internship
University of Illinois at Chicago
College of Medicine
Herand Abcarian, M.D. Chairman
Department of Surgery (M/C 958)
840 South Wood Street
Suite 515, 911 Building
Chicago, Illinois 60612
(312) 996-2061
July 1, 1991 – June 30, 1992

MEDICAL SCHOOL
M.D., Medical College of Wisconsin
8701 Watertown Plank Road
Milwaukee, Wisconsin 53226
(414) 456- 8206
August, 1987 – May, 1991

UNDERGRADUATE
B.S., University of Wisconsin-Milwaukee
2200 East Kenwood Blvd
P.O. Box 413
Milwaukee, Wisconsin 53221
Target MD Program
(414) 229-5774
August, 1984 – May, 1987

ACTIVITIES & AWARDS

FELLOWSHIP

Assistant Team Physician Drexel University
Assistant Team Physician Community College
of Pennsylvania
Team Physician Philadelphia Public & Private
High School Football League

CPR Certification January 2018

RESIDENCY

Assistant Team Physician University of Illinois
At Chicago, 1994 & 1995
Senior Resident Cook County Hospital, 1996

MEDICAL SCHOOL

Recipient of Medical College of Wisconsin
Summer Research Fellowship, 1988
Class Representative to Curriculum and Evaluation
Committee, 1987 – 1988

UNDERGRADUATE

Three Year Accelerated Target MD Program
Senior Advisor Phi Eta Sigma Honor Society
President Phi Eta Sigma Honor Society
Vice-President Phi Eta Sigma Honor Society
Phi Eta Sigma Honor Society
Dean's List
Outstanding Academic Achievement Award
University of Wisconsin-Milwaukee Varsity Tennis Team

RESEARCH AND PUBLICATIONS

Armagan O, Shereff MJ: Injuries of the Toes and Metatarsals. In Abidi N, Lin S: Foot and Ankle Trauma. OCNA, Jan 2001.

FELLOWSHIP

Author Book Chapter

Armagan O, Shereff MJ: Tendon Injury and Repair. In Meyerson M: Foot and Ankle Disorders. W.B. Saunders, Philadelphia. 2000.

RESIDENCY

Restoration of Femoral Offset During Total Hip Arthroplasty: Is the Preoperative Radiograph Adequate?
Mentor: Michael C. Moran, M.D.

The Intra and Interobserver Reliability of the Classification of Acetabular Defects.
Mentor: Michael C. Moran, M.D.

MEDICAL SCHOOL

Project Assistant to Charles R. Wilson, Ph.D., Associate Professor in the Department of Radiology at the Medical College of Wisconsin, during the Summers of 1987 and 1988, collaborating on the following topics:

Relative Contribution of Cortical and Trabecular Bone in Osteoporosis of Vertebral Spine and Femoral Neck.

Publication Review and Synopsis: "Incidence and Epidemiology of Hip Fractures." (38 pages).

UNDERGRADUATE

Project Assistant to David H. Petering, Ph.D., Professor in the Department of Biochemistry at the University of Wisconsin-Milwaukee, during the Fall of 1986, on the following topics:

Binding Capacity, Affinity and and Efficiency of Chelex for Zinc and Calcium Ions

Iron Metabolism in Ehrlich Ascites Tumor Cells.

PRESENTATIONS

Clinical Lab Faculty Instructor
Arthroscopy Association of North America
Masters Experience in Arthroscopy of the Foot and Ankle
Rosemont, Illinois
October 30 - 31, 1999
August 12 – 13, 2000
October 12 – 13, 2002
August 15 – 16, 2003
October 2 – 3, 2004
November 4 – 5, 2006
September 13, 2008
September 25-26, 2010
September 17, 2011

Clinical Lab Faculty Instructor
American Orthopaedic Foot and Ankle Society
Trauma to the Foot and Ankle
A Surgical Skills Course
Rosemont, Illinois
November 17 – 19, 2000

FELLOWSHIP

Visiting Instructor, 10th Annual Sports Medicine Symposium
Medical College of Wisconsin, March 26-27, 1998
Hugh Hickey Visiting Foot Professor Lecture
Foot and Ankle Residents Conferences
Monthly Sports Medicine Conferences to Residents
Monthly Pennsylvania Orthopaedic Society for Sports Medicine

RESIDENCY

Restoration of Femoral Offset During Total Hip Arthroplasty:
Is the Preoperative Radiograph Adequate?
Senior Thesis Day, Friday, June 21, 1996

"Density Analysis of Femurs as Related to Strength."
Student Research Day, August 1988
Medical College of Wisconsin

PROFESSIONAL ORGANIZATIONS

American Academy of Orthopaedic Surgeons
(Member # 088976), 1992 - present
American Orthopaedic Foot and Ankle Society
1997 - present
(Member of Subcommittee on Sports Medicine, 2002-2004)
Western Orthopaedic Association, 2008 - present
California Orthopedic Association 2009 - present
Ventura County Medical Society 2009 – present
Armenian American California Medical Society 2008 - present
Founding Member Chicago Sports Medicine Society, 1993
Orthopedic Trauma Association, 2015 – present

LICENSURE

Diplomate of the National Boards of Medical Examiners,
March, 1992, #403592

American Board of Orthopaedic Surgeons,
Part I Written Exam, 1996, Passed

American Board of Orthopaedic Surgeons,
Part II Oral Exam, July 2000, Passed

Recertification in July 2010 - Passed
Recertification in July 2020 - Passed

Board Certified until 12/2030

Illinois	036-087574	07/31/93 – 07/31/2023
Wisconsin	38392-020	10/31/1996 – 10/31/2023
California	G 88110	04/30/2007 – 04/30/2023
UPIN	G53091	
PTAN	EJ 902 A (Medicare)	
NPI	1235433228 group 1265462337 individual	
TAX ID	27-2116158	
Medi-Cal #	1235433228 PIN 4349041	

Fluoroscopy X-Ray Supervisor and Operator Permit,
RHC 167762. Issued 2009, valid until 4/30/2021

X-Ray Supervisor and Operator Permit, # RHC 00205890
Valid until 12/31/2022

QME – passed exam 10/2018, certified 12/2018

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OSEP E. ARMAGAN, M.D.
A Professional Corporation

Diplomate American Board
of Orthopaedic Surgery

Sample Report

[redacted]

RE: [redacted]

Date of Birth: [redacted]
Date of Injury: [redacted]
Date of Orthopedic Independent Medical Examination: [redacted]

WCAB Case No: unknown
Insurance Carrier: [redacted]
Employer: [redacted]
Claim Number: [redacted]

INDEPENDENT MEDICAL EXAMINATION
IN THE SPECIALTY OF ORTHOPEDICS

To Whom It May Concern:

This report has been prepared in accordance with Labor Code Section 5307.1 as an Independent Medical Examination. The required complexity factors in this examination included: 2 hours of face-to-face time, 3 hours of record review, and physician's preparation of report of 1 hour with issues of medical causation and issues of apportionment discussed.

[redacted] is a [redacted] year old male who is seen today, [redacted] as per letter of transmittal signed by [redacted], Senior Examiner dated [redacted] with regards to injuries to both of his knees on [redacted] while he was employed as a Fire Captain with [redacted]

All parties denied a recent history of fever, chills, or contact with a known Covid-19 positive person. All parties involved were wearing masks. Non-contact Thermal temperature readings were normal of all parties involved.

HISTORY OF INJURY

[redacted] is a [redacted] year-old male who began his employment with the [redacted] on [redacted]. Prior to his employment with the [redacted] he denied any injuries or pain, missing any time from work, or seeking any medical care with regards to his bilateral knees. He was promoted to a [redacted] 2 ½ years ago. His work schedule rolls per 24 hour shifts. He described he worked Wednesdays 7:00 am to Thursday 7:00 am, then Friday 7:00 am to Saturday 7:00 am, then Sunday 7:00 am to Monday 7:00 am, then Tuesday 7:00 am to Wednesday 7:00 am, 4 24-hour shifts, followed by 6 days off; then a cluster of 3 day 24 hour shifts, followed by 4 days off. He occasionally does 1-2 overtime shifts per month, during his off days. His daily clothing and gear weigh about 25 lbs.

He was performing his usual and customary duties up until his specific date of injury on [redacted] On that date, [redacted] described he was driving to a structure on fire. He was on the radio discussing the details regarding the fire, when he stepped out of his truck. As he stepped out of his truck, he was carrying a 40 lbs. shoulder strap of equipment. As he stepped onto his left leg, he slipped in the wet mud and fell to the ground. He reported his twisted both knees as he fell to ground. He was able to get up and continue to perform his regular duties for the remainder of his 24 hour work shift. He stated he initially reported his injury to his supervisor, but is unsure if paperwork was filled out. He initially reported his symptoms as mild. As he continued to work his regular 24 hour shifts, he stated his left knee progressively started to swell. He bought himself a neoprene knee sleeve to help control his left knee pain and swelling.

His symptoms of pain and swelling in both knees continued to increase, and he was referred to an urgent care clinic. I have a Doctor's First Report of Occupational Injury or Illness on [redacted] by [redacted] M.D. She described left knee swelling, with moderate pain to palpation of the lateral knee and popliteal fossa. Range of motion was normal and no ligamentous instability was noted on exam. She described right knee swelling, with moderate pain of the lateral knee and popliteal fossa. Range of motion was normal and no ligamentous instability was noted on exam. Bilateral Knee xrays were read as normal. She recommended bilateral knee MRI's. [redacted] was allowed to return to full duty.

The following day, on [redacted] he underwent bilateral knee MRI's. The MRI of Left Knee without Contrast from [redacted] Medical Group Inc., by [redacted] M.D. showed: 1) Horizontal tear of the body of the medial meniscus. 2) Diffuse ACL mucoid degeneration. 3) Mild to moderate patellofemoral joint chondral loss. 4) Baker's cyst. 5) Mild patellar tendinosis at the origin and insertion. 6) Mild curvilinear edema in Hoffa's fat pad may represent recent infrapatellar plica injury. 7) Baker's cyst. 8) Mild joint effusion.

The MRI of Right Knee without Contrast from [redacted] Medical Group Inc., by [redacted] M.D. showed: 1) Horizontal flap tear of the posterior horn and body of the medial meniscus with displacement into the superior meniscotibial recess. 2) Mucoid degeneration of the ACL. 3) Moderate medial joint compartment degenerative changes. 4) Diffuse patellar tendinosis. 5) Small joint effusion. 6) Small Baker's cyst.

Since his injury on [redacted] has continued to perform his usual and customary duties without restrictions or missing any time from work. He has undergone multiple cortisone injections and visco-supplementation injections into both knees with moderate relief.

PAST MEDICAL HISTORY

[redacted] denied a history of diabetes, heart, respiratory, liver, renal, thyroid, cholesterol, or cancer.

He describes a recent history of GI Upset, related to Ibuprofen use

Surgical History:
[redacted] - Right wrist ORIF [redacted]

Allergies: No known drug allergies.

Current Medications:
Ibuprofen 600 mg po qhs for knee pain for past 2 years

Social History:
He denied a smoking history
He described light social alcohol use
He denied marijuana orc illicit drug use

Family History:

His mother – alive[redacted], cardiac history, pacemaker
His father – alive[redacted], HTN, smoker, defibrillator
[redacted]

Previous Injuries:
He denied any Motor Vehicle Accidents
He denied any sports injuries or slip and fall injuries
He sustained a nonindustrial fall off horse in 2013, fracturing both wrists,
Light duty for 6 months: Left wrist – casted, Right wrist – surgery

Prior Industrial Injuries:

In [redacted] while working for the [redacted] as a [redacted], he was carrying a 350 lbs. woman out of a burning building and sustained lower back pain. He reported the injury to his supervisor, went to an urgent care and had xrays. He was told he had any injury to his "scotty dog", pars articularis. He stated he received some physical therapy, and was placed on light duty for 1 month, and then returned to full duty without restrictions. He denied any settlement or permanent and stationary report being filed.

Employment History:

From [redacted] he worked for the [redacted] as a [redacted] in [redacted] He denied any injuries or pain, missing any time from work or seeking any medical care. From [redacted] to [redacted] he worked as a self-employed landscaper. The last 2 years, this work was concurrent with his employment with the [redacted] as a Fire Fighter. He denied any injuries or pain, missing any time from work or seeking any care during his self-employment as a [redacted]

Job Analysis

I have a Job Analysis for a [redacted]. Work Hours 40-56 hours per week. 2 1/3 day shifts or 5 days per week. Date[redacted] signed by [redacted] Chief

Type of Equipment Used:
Various Hand Tools, Ladders, Fire Hoses, Radios, Ropes, Breathing Apparatus
Vehicles:
Possible driving Emergency Vehicles
Physical Movements:
Frequently: Walking, Sitting, Standing, Indoors, Outdoors, Walking Indoors
Occasionally: Twisting, Stooping, Bending, Squatting, Kneeling, Crawling, Climbing Stairs, Climbing Ladders, Walking Outdoors, Working Heights.
Physical Demands:
Lifting/up to 10 lbs., Lifting/11-24 lbs., Lifting/25 – 50 lbs., Lifting/51-100lbs., Lifting/ 100 + lbs.,
Carrying/up to 10 lbs., Carrying/11-24 lbs., Carrying/25-50 lbs., Carrying/50 +
Reaching/above shoulder, Reaching/at shoulder, Reaching/below shoulder
Dependent Upon Emergencies:
Pushing/up to 50 lbs., Pushing/50-100 lbs., Pushing/100 lbs. +
Pulling/up to 50 lbs., Pulling/50-100 lbs., Pulling/100 lbs.
Hand Manipulation, Simple Grasping, Power Grasping, Fine Manipulation
Environmental Exposures:
Driving cars, trucks, forklifts or other equipment

Working near hazardous material
Walking on uneven ground, Walking in slippery services
Exposure to dust, gas or fumes, Exposure to noise, Exposure to extremes in temperature or humidity
Work at heights

REVIEW OF MEDICAL RECORDS OF TODD PAYNE:

[redacted] – Doctor's First Report of Occupational Injury or Illness by [redacted] M.D. Date of injury was [redacted] While employed by the [redacted] as a [redacted], in [redacted] he arrived to a structure fire at the time of the incident. He was talking on the radio relaying information in regards to the situation. He then stepped out of the vehicle upon and slipped in the wet mud and fell to the ground. He twisted both of his knees during the fall. The symptoms initially were slight and were reported but medical evaluation was not initially requested. He continued regular work. He finished the shift and continued to work the next scheduled shifts. Symptoms persisted. On exam, left knee was abnormal. There is swelling of the knee. There is moderate pain to palpation of the lateral knee and popliteal fossa. Examination of the right knee was abnormal. There was swelling of the knee. There was moderate pain to palpation of the lateral knee and popliteal fossa. Diagnoses: 1) Sprain of unspecified site of right knee. 2) Sprain of unspecified site of left knee. X-rays of left knee, tibia and fibula, and x-rays of right knee, tibia and fibula, MRI of bilateral knees, and medications were recommended. Patient may perform usual work.

[redacted] – MRI of Right Knee without Contrast from [redacted] by [redacted] M.D. Conclusion: 1) Horizontal flap tear of the posterior horn and body of the medial meniscus with displacement into the superior meniscotibial recess. 2) Mucoid degeneration of the ACL. 3) Moderate medial joint compartment degenerative changes. 4) Diffuse patellar tendinosis. 5) Small joint effusion. 6) Small Baker's cyst.

[redacted] – MRI of Left Knee without Contrast from [redacted] Medical Group Inc., by [redacted], M.D. Conclusion: 1) Horizontal tear of the body of the medial meniscus. 2) Diffuse ACL mucoid degeneration. 3) Mild to moderate patellofemoral joint chondral loss. 4) Baker's cyst. 5) Mild patellar tendinosis at the origin and insertion. 6) Mild curvilinear edema in Hoffa's fat pad may represent recent infrapatellar plica injury. 7) Baker's cyst. 8) Mild joint effusion.

[redacted] – Primary Treating Physician's Progress Report (PR-2) by [redacted] Patient slipped out of a vehicle and stepped on a hole injuring both knees. Currently, he complained of pain predominantly of the lateral knee and medial knee. Diagnoses: 1) Sprain of unspecified site of right knee. 2) Sprain of unspecified site of left knee.

Requested referral to [redacted] for evaluation and treatment of right and left meniscus tear. Return to full duty without limitations or restrictions.

[redacted] – Initial Orthopedic Consultation from [redacted] Institute by [redacted] PA-C. Date of injury was [redacted] Patient complained of bilateral knee pain. On 03/20/18, while working a fire, he stepped off the engine leading with his left foot when the breathing apparatus that was over his left shoulder swung around and knocked him off balance. He ended pivoting on left leg and stumbling out. He experienced pain in the knees at the time. About an hour, while taking to a colleague, he stepped into an open fence post hole with his left foot exacerbating pain in the left knee. At the time, he continued working hoping his symptoms would improve, but did not. In June, he was referred to [redacted] He underwent x-rays and MRIs of the knees and was then referred to this examiner's office for consultation. On exam, right knee showed mild swelling. He had moderate tenderness to palpation over the medial joint line and over the anterior medial aspect of the knee. Left knee showed mild swelling. He had moderate tenderness to palpation over the medial joint line and over the anterior medial aspect of the knee. X-rays of bilateral knees today showed joint spaces were fairly well maintained although there were degenerative changes noted in the medial and patellofemoral compartment. Impression: 1) Bilateral knee osteoarthritis. 2) Bilateral knee medial meniscus tear. Discussed conservative treatment and surgical intervention. He elected to proceed with intra-articular corticosteroid injections and use of anti-inflammatory medication. He was provided a prescription for meloxicam. Also discussed the role of surgical intervention for arthroscopy, chondroplasty and partial medial meniscectomy. He finds the left knee to be most symptomatic and will likely consider the left knee surgery first if he fails conservative treatment. Both knees were injected with 5 mL of 2% lidocaine and 1 mL of Kenalog. No difficulties were encountered during the injection. Work restrictions per PTP.

[redacted] – Primary Treating Physician's Progress Report (PR-2) by [redacted] Patient complained of pain in right and left knees. Patient was status-post cortisone injections with significant improvement. Diagnoses: 1) Sprain of unspecified site of right knee. 2) Sprain of unspecified site of left knee. Treatment plan continued.

[redacted] – Secondary Treating Physician's Progress Report from [redacted] Institute by [redacted] PA-C. Date of injury was [redacted] Patient presented today for re-evaluation of bilateral knees. He was being treated conservatively for bilateral medial meniscus tears and osteoarthritis. He was treated with bilateral intra-articular corticosteroid injections on [redacted] He noted significant improvements in his knee symptoms following the injections. His right knee was still doing very well. He had increased swelling in the left knee with pressure in the posterior lateral aspect of the knee and intermittent symptoms of numbness and tingling going down towards his foot. The symptoms of numbness and tingling resolved after the injection and have returned as the injection seemed to be wearing off. On exam, right knee had minimal tenderness to

palpation over the medial joint line. He had lateral joint line tenderness. He had full knee range of motion with subtle patellofemoral crepitus. Left knee had mild swelling, and moderate tenderness to palpation over the medial joint line and over the anterior medial aspect of the knee. He also had moderate tenderness to palpation over the medial posterior aspect of the knee and with palpation he felt intermittent numbness and tingling radiating down the lateral leg. Impression: 1) Bilateral knee osteoarthritis. 2) Bilateral knee medial meniscus tear. Continued conservative treatment and observation were advised. Patient would like to proceed with physical therapy. If he remains symptomatic, will proceed with surgery of arthroscopy, chondroplasty, and partial medial meniscectomy. Work status was per primary treating physician.

[redacted] – Therapy Notes from [redacted] Physical Therapy by [redacted], P.T. Patient was seen approximately 12 times for his bilateral knees. Treatment plan included therapeutic exercises/activity, neuromuscular re-education, manual therapy, modalities, and home exercise program.

[redacted] – Primary Treating Physician's Progress Report (PR-2) by [redacted] Patients' knee symptoms were essentially unchanged. There was slight to moderate pain of the medial knee and popliteal fossa. Diagnoses: 1) Sprain of unspecified site of right knee. 2) Sprain of unspecified site of left knee. Continue to follow while awaiting physical therapy and treatment of the specialist. Return to full duty.

[redacted] – Secondary Treating Physician's Progress Report by [redacted] M.D. Patient presented for follow-up of his bilateral knees. The right knee did not cause him significant pain. Occasionally, he will have swelling in the posterior aspect of the right knee and he also develops calf pain which was present bilaterally. He had anterior and medial sided left knee pain. He developed posterior swelling and symptoms seem to be worse at the end of the day. Activities such as ascending stairs or climbing stairs caused significant left-sided anterior knee pain. On exam, patient had some tenderness to palpation along the medial joint line. There was also some tenderness posteriorly with mild fullness in the popliteal fossa. Impression: 1) Right knee osteoarthritis with degenerative medial meniscus tear and popliteal cyst. 2) Left knee patellofemoral chondromalacia/osteoarthritis with degenerative horizontal cleavage test of the medial meniscus and Baker's cyst. Despite the MRI findings, the patient was minimally symptomatic in the right knee and would not recommend any treatment for the medial meniscus tear and medial compartment osteoarthritis at this point in time. For the left knee, recommendation would be for continued therapy for participation in a home exercise program, use of oral anti-inflammatories medications and weight loss. Also discussed the possibility of a viscous supplementation injection. He was experiencing bilateral calf pain. He was advised that this may be arising from his cholesterol medication and may not be related to his knee pathology. Work status was per primary treating physician.

[redacted] – Secondary Treating Physician's Progress report by PA [redacted] Patient presented for Synvisc one injection of the left knee. He was treated conservatively for bilateral medial compartment osteoarthritis and medial meniscus tears. He did very well following the right knee corticosteroid injections. He did very well following the right knee corticosteroid injection and had minimal discomfort. He noted some improvements in his calf symptoms with discontinuing his cholesterol medication. He was requesting repeat intra-articular corticosteroid injection to the right knee. Impression: 1) Right knee osteoarthritis with degenerative medial meniscus tear and popliteal cyst. 2) Left knee patellofemoral chondromalacia/osteoarthritis with degenerative horizontal cleavage tear of the medial meniscus and Baker's cyst. Left knee was injected with 3 mL of lidocaine and 6 mL of Synvisc. Right knee was injected with 5 mL of 2% lidocaine and 1 mL of Kenalog (40mg/ml). No difficulties were encountered during the injection. Patient was instructed to use ice, heat, and OTC pain medications as necessary to control any pain or swelling.

[redacted] – Primary Treating Physician's Progress Report (PR-2) by [redacted] Patient was currently working without restrictions. He was treated by Dr. Shapiro and received injections to each of his knees. He reported that the knee symptoms were improving. There was slight to moderate pain of the knee. Diagnoses: 1) Sprain of unspecified site of right knee. 2) Sprain of unspecified site of left knee. Treatment plan continued.

[redacted] – Secondary Treating Physician's Progress report by [redacted] Patient presented for re-evaluation of bilateral knees. Patient reported intermittent pain and swelling although less severe since the injections. Impression: 1) Right knee osteoarthritis with degenerative medial meniscus tear and popliteal cyst. 2) Left knee patellofemoral chondromalacia/osteoarthritis with degenerative horizontal cleavage tear of the medial meniscus and Baker's cyst. Will continue to observe his symptoms. He will continue to modify activity as needed. Advised to continue with ice, heat, and medication as needed. Discussed repeating the left knee Visco supplementation and considering this for the right knee as well. Follow-up in 3-4 months, sooner as needed. Work status per primary treating physician.

[redacted] - Secondary Treating Physician's Progress report by [redacted] Patient presented to the office today with expectations of proceeding bilateral Synvisc-One injections. Impression: 1) Right knee osteoarthritis with degenerative medial meniscus tear and popliteal cyst. 2) Left knee patellofemoral chondromalacia/osteoarthritis with degenerative horizontal cleavage tear of the medial meniscus and Baker's cyst. Patient expected to proceed with bilateral Synvisc injections today. Unfortunately, this examiner did not have authorization to proceed with these injections on today's visit. Will submit for follow-up with his insurance and he will return to the office once these are approved. Work status per primary treating physician.

[redacted] – Primary Treating Physician's Progress Report (PR-2) by [redacted] P.A. Patient was currently being treated by [redacted] who recommended visco-

supplementation injections. These were recently authorized and were pending scheduling. Patient reported that symptoms from the bilateral knee post-traumatic osteoarthritis were slightly worse after a prolonged period of relief since the most-recent injection. Diagnoses: 1) Sprain of unspecified site of right knee. 2) Sprain of unspecified site of left knee. Treatment plan continued. Advised to return to full duty.

[redacted] – Secondary Treating Physician's Progress report by [redacted] Patient presented for Synvisc injections for the bilateral knees. Diagnosis: Bilateral knee osteoarthritis.

[redacted] – Work Status Summary by [redacted] M.D. Diagnoses: 1) Sprain of unspecified site of right knee. 2) Sprain of unspecified site of left knee. The patient was discharged at maximum medical improvement (MMI) as permanent and stationary and may continue regular work without restrictions. Except for any medications provided today or tests which may have been obtained today for rating purposes, there was no current need for active treatment except the currently scheduled visco-supplementation injections. There will be an impairment rating (WPI) for this injury. Patient requires a provision for future medical evaluation and/or treatment on a work-related basis. There was a need for future medical evaluation or treatment of the both knees which should consist of office evaluations by the PTP, provision for NSAIDs and occasional opioid medications if deemed necessary by the PTP and provisions for orthopedic re-evaluation approximately every 6 months for injections of visco-supplementation. Discharged from care on [redacted]

[redacted] – Secondary Treating Physician's Progress report by [redacted] Patient presented for re-evaluation of bilateral knee. He was interested in repeating the injections in order to continue with conservative treatment options. Impression: 1) Right knee osteoarthritis with degenerative medial meniscus tear and popliteal cyst. 2) Left knee patellofemoral chondromalacia/ osteoarthritis with degenerative horizontal cleavage tear of the medial meniscus and Baker's cyst. Patient had extensive conservative treatment with therapy, activity modification, medication, cortisone injections, and visco-supplementation. Requested repeat injections and try to continue with injections every 6 months as this had been very beneficial to the patient. Follow-up with authorization for bilateral Synvisc-One injection. Work status per primary treating physician.

[redacted] – Secondary Treating Physician's Progress report by [redacted] Patient presented for Synvisc injection for the bilateral knee. 1) Right knee osteoarthritis with degenerative medial meniscus tear and popliteal cyst. 2) Left knee patellofemoral chondromalacia/osteoarthritis with degenerative horizontal cleavage tear of the medial meniscus and Baker's cyst. Bilateral knees were injected with 6ml of Synvisc. Patient was instructed to use ice, heat, and OTC pain medications as necessary. If he noted any increased pain or swelling, he should contact the office immediately. Work status per primary treating physician.

[redacted] – Primary Treating Physician's Permanent and Stationary Report (PR-4) by [redacted] M.D. Date of injury was [redacted] Date of exam was [redacted] The patient worked as a Fire Captain. In [redacted] he had arrived to a structure fire at the time of the incident. He was talking on the radio relaying information in regards to the situation. He then stepped out of the vehicle upon and slipped in the wet mud and fell to the ground. The firefighter twisted both of his knees during the fall. The symptoms initially were slight. The symptoms were reported but medical evaluation was not initially requested. The patient continued regular work. He finished the shift and continued to work the next scheduled shifts. His symptoms persisted. Medical evaluation was requested three months later the incident when the symptoms did not improve. The patient was then referred for medical evaluation and treatment. He denied any other injuries as a result of this incident. He denied similar injuries to these body parts. Currently, he complained that the left knee symptoms were essentially unchanged. There was pain of the anterior knee. He complained of clicking of the knee. There were no paresthesias distal to the knee. There were no limitations of the patient's ability to perform normal activities of daily living. Diagnoses: 1) Sprain of unspecified site of right knee. 2) Sprain of unspecified site of left knee. 3) Bilateral post-traumatic osteoarthritis of hip. 4) Tear of medial meniscus, left knee. 5) Other tear of medial meniscus, right knee.

X-rays of both knees were normal. There was a 2% impairment of the whole person. There was a 1% impairment of the whole person from the left knee injury. The patient has a 2% impairment of the left lower extremity and a 1% impairment of the whole person because of the medial meniscus tear from Table 17-33 on page 546. There is no leg length discrepancy, skin loss, peripheral nerve injury or vascular injury. There is no evidence of CRPS and there is no ratable arthritis as the cartilage intervals are greater than 4 mm. In addition, there is no gait derangement, muscle atrophy or abnormal range of motion. Muscle strength of the leg is normal. There is a 1% impairment of the whole person from the right knee injury. The patient has a 2% impairment of the right lower extremity and a 1% impairment of the whole person because of the medial meniscus tear from Table 17-33 on page 546. There was no leg length discrepancy, skin loss, peripheral nerve injury or vascular injury. There is no evidence of CRPS and there is no ratable arthritis as the cartilage intervals are greater than 4 mm. In addition, there is no gait derangement, muscle atrophy or abnormal range of motion. Muscle strength of the leg is normal. Combining these impairments utilizing the Combined Values Chart from pages 604 to 606 results in a 2% impairment of the whole person. With regard to apportionment, 100% of the impairment should be attributed to the work injury. The patient was discharged at maximum medical improvement (MMI) as permanent and stationary and may continue regular work without restrictions. Except for any medications provided today or tests which may have been obtained today tor rating purposes, there was no current need for active treatment except the currently scheduled visco-supplementation injections. The patient requires a provision for future medical evaluation and/or treatment on a work-related basis. There is a need for future medical evaluation or treatment of the both knees. There should be a provision for future medical evaluation and treatment consisting

of office evaluations by the PTP. There should be a provision for NSAIDs and occasional opioid medications if deemed necessary_by the PTP. In addition, there should be provisions for orthopedic re-evaluation approximately every 6 months for injections of visco-supplementation.

There were also miscellaneous records and non-orthopedic reports including proofs of service, fax sheets, and duplicate reports.

PRESENT COMPLAINTS:

His primary area of complaint is his bilateral knees. His right knee bothers him more than the left. He denied any specific injury to his right knee. He stated his right knee bothers him every day, almost constantly at a baseline level of 3 out of 10. He describes achy nighttime stiffness. His right knee does lock. His right knee does not buckle or feel weak. He has not fallen. Prolonged standing and walking do not aggravate his symptoms. Walking on uneven ground will aggravate his symptoms. He stated repetitive squatting, kneeling and ascending and descending of stairs will aggravate his pain to a level 4-5/10. On [redacted] he underwent an MRI of the Right Knee without Contrast from [redacted] read by [redacted] M.D., which showed: 1) Horizontal flap tear of the posterior horn and body of the medial meniscus with displacement into the superior meniscotibial recess. 2) Mucoid degeneration of the ACL. 3) Moderate medial joint compartment degenerative changes. 4) Diffuse patellar tendinosis. 5) Small joint effusion. 6) Small Baker's cyst. He has undergone 2 cortisone injections to his right knee, the first on [redacted] and the second on [redacted] with mild relief. He has undergone 2 synvisc-one visco-supplementation injections to his right knee, the first on 08/20/2019 and the second on [redacted] He has not been offered right knee surgery by [redacted] M.D. nor does [redacted] want surgery on his right knee. He does occasionally wear a soft neoprene knee sleeve on his right knee at work, which he purchased on his own.

He described his left knee pain started when he stepped down and twisted in the mud on [redacted] nied any specific injury to his right knee. He stated his left knee bothers him every day, almost constantly at a baseline level of 2 out of 10. He describes achy nighttime stiffness. His left knee does lock. His left knee does not buckle or feel weak. He has not fallen. Prolonged standing and walking do not aggravate his symptoms. Walking on uneven ground will aggravate his symptoms. He stated repetitive squatting, kneeling and ascending and descending of stairs will aggravate his pain to a level 4-5/10. On [redacted] he underwent an MRI of the Left Knee without Contrast from [redacted], read by [redacted] M.D., which showed: 1) Horizontal tear of the body of the medial meniscus. 2) Diffuse ACL mucoid degeneration. 3) Mild to moderate patellofemoral joint chondral loss. 4) Baker's cyst. 5) Mild patellar tendinosis at the origin and insertion. 6) Mild curvilinear edema in Hoffa's fat pad may represent recent infrapatellar plica injury. 7) Baker's cyst. 8) Mild joint effusion. He has undergone 1 cortisone injection to his left

knee, on [redacted] with mild relief. He has undergone 3 synvisc-one visco-supplementation injections to his left knee, the first on [redacted] the second on [redacted] and the third on [redacted] He has not been offered left knee surgery by [redacted] nor does [redacted] want surgery on his left knee. He does occasionally wear a soft neoprene knee sleeve on his left knee at work, which he purchased on his own.

ACTIVITIES OF DAILY LIVING:

Regarding Activities of Daily Living (Fifth Edition, AMA Guides, page 4, table 1-2), under self-care personal hygiene, he reported a normal 1 out of 5 level of difficulty with his ability to urinate, defecate, brush his teeth, comb his hair, bath himself, dress himself, and eat by himself. Under communication skills, he reports a normal 1 out of 5 level of functioning with his ability to write, type, see, hear, and speak. Under physical activities, he reports a normal 1 out of 5 level of functioning with his ability to stand, sit, recline, walk, and go up and down stairs. Under sensory function, he reports a normal 1 out of 5 level of functioning with his ability to hear, see, feel, taste, and smell. Under hand activities, he reports a normal 1 out of 5 level of functioning with his ability grasp or grip, lift, and manipulate small items. Under travel, he reports a normal 1 out of 5 level of functioning with his ability to ride in a car or bus, and travel by plane. Under restful night sleep pattern, he reports a normal 1 out of 5 level of functioning. Under sexual function, he reports a 3 out of 5 level of difficulty. This form was signed by [redacted] on [redacted]

Under Questions Concerning Activities of Daily Living, he reports he can look after himself normally without extra discomfort. He can lift and carry heavy objects but with extra discomfort. There is no change is his ability to walk. He reports the most strenuous level of activity he can do for at least 2 minutes is heavy activity to very heavy activity. He can climb 1 flight of stairs with no difficulty. He can only sit between 30 and 60 minutes at a time. He can only stand or walk without any limitations. He has no difficulty reaching and grasping something off a shelf at chest level. He has no difficulty reaching and grasping something off a shelf overhead. He can push or pull very heavy objects. He has no difficulty with gripping, grasping, holding, and manipulating objects with his hands. He has no difficulty with repetitive motions such as typing on a computer. He has no difficulty with forceful activities of his arms and hands. He has some difficulty with kneeling, bending, or squatting. His sleep is mildly disturbed. In regards to his sexual function, he reports there has been no change. In regards to pain at the moment, he states his pain is mild at the moment. In regards to his pain most of the time, his pain is mild most of the time. His injury and/or pain interferes with his ability to travel none of the time. His injury and/or pain interferes with his ability to engage in social activities none of the time. His injury and/or pain interferes with his recreational activities some of the time. His injury and/or pain interferes with his concentrating and thinking some of the time. His injury and/or pain has caused emotional distress with depression and anxiety none of the time. He reports

no change with writing, typing, seeing, hearing, and speaking. His pain level on the average during the past week was a 2 out of 10 and his pain level at its worst over the past week was a 4 out of 10, primarily related to his both of his knees. This form was signed by Todd Payne on [redacted]

Regarding Activities of Daily Living, per table 18-4, Ratings Determining Impairment Associated with Pain, he had a score of 12 points. This form was signed by [redacted] on [redacted]

PHYSICAL EXAMINATION:

[redacted] is a middle-aged man sitting comfortably on the examining bed in no acute distress. He is 6'0" tall, and weighs 220 pounds. He has lost 45 lbs. over the past 2 years with modification of diet and exercises.

Vital signs:

Temperature (forehead noncontact)	97 F
Blood pressure:	125/80
Pulse:	75

On Sensory examination, he has diminished sensation on the outer aspect of his left thigh, but equal and symmetric sensation on the inner aspects of his upper thighs, inner and outer aspects of his calves, dorsum, lateral, and plantar aspects of both feet.

Motor Examination of the Lower Extremities:

	Left	Right
Hip Flexion	5/5	5/5
Hip Extension	5/5	5/5
Hip Abduction	5/5	5/5
Hip Adduction	5/5	5/5
Hip External Rotation:	5/5	5/5
Hip Internal Rotation:	5/5	5/5
Knee Flexion	5/5	5/5
Knee Extension	5/5	5/5
Ankle Dorsiflexion	5/5	5/5
Ankle Plantar Flexion	5/5	5/5
Foot Inversion	5/5	5/5
Foot Eversion	5/5	5/5
Toe Flexion	5/5	5/5
Toe Extension	5/5	5/5
EHL Extension	5/5	5/5

Reflexes:

	Left	Right
Patellar	+1	+1
Achilles	+1	+1

Leg Circumferential Measurements:

	Left	Right
Thigh (10 cm proximal to the knee):	49.0 cm	49.0 cm
Knee:	45.5 cm	45.5 cm
Calf:	45.5 cm	45.5 cm
Ankle:	26.0 cm	25.5 cm

On Gait evaluation, he stands with weight borne equally on both legs. He has a mild right knee varus deformity. He walks with a normal toe/ heel gait, with a normal cadence and stride length. He is able to walk on his tiptoes. He walked down our hallway without a cane or any assistive devices nor any knee braces.

Knees

On Inspection of the left knee, there are deformities, atrophy, lesions or asymmetry noted.

On Palpation of the left knee, there is medial joint line tenderness. There is no tenderness on the lateral joint line, or patellofemoral or the tibial tubercle regions.

On Palpation of the right knee, there is lateral joint line tenderness and on the tibial tubercle. He has no tenderness on the medial joint line and patellofemoral regions.

Range of Motion of the Knees:

	Left	Right
Extension:	0,0,0 deg	+5,+5,+5 deg
Flexion:	135,130,135 deg	130,125,130 deg

Special Tests:

	Left	Right
ACL instability:	trace	Positive
PCL instability:	Negative	Negative
Varus instability:	Negative	Negative
Valgus instability:	Negative	Negative
Patellar instability:	Negative	Negative
Apprehension:	Negative	Negative
Patellofemoral crepitus:	Negative	Positive
McMurray's test:	Negative	Negative

XRAYS:

Standing View of Bilateral Knees: There is mild right knee anatomic neutral alignment of 0 degrees. The right knee medial joint line measures 4.4 mm. The left knee medial joint space measures 4.8 mm.

3 Views of the Left Knee show: There are no fractures noted. There is relative preservation of the medial and lateral joint space. The tibial spines are intact. There is a large superior patellar traction osteophyte noted. The lateral patellofemoral joint measures 5.6 mm. There are small osteophytes noted on the anterior femoral condyle.

3 Views of the Right Knee show: There are no fractures noted. There is relative preservation of the lateral joint space, with slightly diminished medial joint space. The tibial spines are intact. There is a large superior patellar traction osteophyte and a small inferior osteophyte noted. The are small osteophytes noted on the tibial spines. The lateral patellofemoral joint measures 5.5 mm. There are small osteophytes noted on the anterior femoral condyle.

IMPRESSION:

[redacted] is a [redacted] year-old male who began his employment with the [redacted] on [redacted]. Prior to his employment with the [redacted] he denied any injuries or pain, missing any time from work, or seeking any medical care with regards to his bilateral knees. He was promoted to a Fire Captain 2 ½ years ago. He was performing his usual and customary duties up until his specific date of injury on [redacted] On that date, [redacted] described he was driving to a structure on fire. He was on the radio discussing the details regarding the fire, when he stepped out of his truck. As he stepped out of his truck, he was carrying a 40 lbs. shoulder strap of equipment. As he stepped onto his left leg, he slipped in the wet mud and fell to the ground. He reported his twisted both

knees as he fell to ground. Since his injury on [redacted] has continued to perform his usual and customary duties without restrictions or missing any time from work. He has undergone multiple cortisone injections and visco-supplementation injections into both knees with moderate relief.

DIAGNOSES:

1. Right Knee sprain and strain, with medial meniscus tear, ACL laxity, with medial compartment cartilage loss and neutral anatomic alignment

2. Left Knee sprain and strain, with medial meniscus tear, and patellofemoral chondromalacia

I do believe the [redacted]s **Permanent and Stationary** and is **Maximally Medically Improved** as of the date of this examination on [redacted]

Work Restrictions

[redacted] continues to work full duty as a [redacted]. I would limit him from prolonged and repetitive ascending and descending of stairs, squatting and kneeling. From an orthopedic standpoint, he is capable of performing his full-time work.

Future Care

I would recommend serial cortisone and visco-supplemental injections be made available to [redacted] every 6 months on an industrial basis. I would allow him to wear neoprene bilateral knee sleeves during his employment on an as needed basis. I would recommend he be switched from Ibuprofen 600 mg to Celebrex 200 mg on a daily basis, to help alleviate his recent GI Upset, aggravated by his daily NSAID's use.

Industrial Causation

I do believe this is industrial causation with regards to [redacted] right and left knee impairment from his specific injury on [redacted] while he was employed as a Fire Captain for the [redacted]

Apportionment

I do not believe there is any apportionment to his knee impairments. He denied any prior industrial or nonindustrial injuries to his knees. I would apportion 100% of his left knee and right knee impairment, to the specific injury dated [redacted] while he was employed as a Fire Captain for the [redacted]

Impairment

Impairment Ratings for the loss of range of motion to the knee is per table 17-10, on page 537. For the left knee, his flexion of 135 deg, gives 0 % WPI and his extension of 0 deg, gives 0 %, WPI. His left knee has normal 3 deg of valgus alignment, which gives 0 % WPI. His left knee has normal strength, no laxity, no atrophy, and no symptoms of CRPS of his left lower extremity. On weight bearing xray measurements, his left medial joint space measures 4.8 mm and his left lateral patellofemoral space measures 5.6 mm, which per table 17-31 on page 544, gives 0 % WPI for his Arthritis Based Impairments. He had no gait abnormality. In summary, his left knee has a combined value of 0 % WPI.

For the right knee, his flexion of 130 deg, gives 0 % WPI, and his loss of +5 full extension gives, 4 % WPI. His neutral anatomical alignment deformity of 0 deg, gives 4% WPI. His right knee has normal strength, no atrophy, and no symptoms of CRPS of his left lower extremity. His right knee has mild ACL laxity, a Diagnosis Based Estimate, which per table 17-33, on page 546, gives 3 % WPI. On weight bearing xray measurements, his right medial joint space measures 4.4 mm and his right lateral patellofemoral space measures 5.5 mm, which per table 17-31 on page 544, gives 0 % WPI for his Arthritis Based Impairments. He had no gait abnormality. His 4 % WPI for his loss of extension, combines with his 4 % WPI for his neutral anatomic alignment to give 8 % WPI. His 3 % WPI for his DBE ACL laxity, does not combine with his range of motion evaluation, per table 17-2, on page 526. In summary, his right knee has a rating of 8 % WPI.

In reviewing his Ratings Determining Impairment Associated with pain score, from table 18-4 on page 576-577, Mr. [redacted] has a score of 12 points. Per table 18-7, on page 584, this corresponds to a mild impairment class, for which I would add 1 point for pain. This provides a total 9 % WPI for [redacted]

I believe this to be an accurate representation of his impairment.

I should like to thank the parties involved for the opportunity of evaluating [redacted] as Orthopedic Independent Medical Examiner.

If there are additional questions, I would be happy to answer interrogatories. Should cross examination become necessary, I respectfully request it be done by deposition in this office.

DISCLAIMERS:

In compliance with the WCAB Rule #10978, Labor Code Section 4628, and AB 3660, the following information is furnished:

History is taken by:	Osep E. Armagan, M.D.
History is reviewed with the patient and edited by:	Osep E. Armagan, M.D.
Physical Examination performed and recorded by:	Osep E. Armagan, M.D.
X-rays Taken by:	Angela Stokes, R.T.
Recorded by:	Osep E. Armagan, M.D.

Interpretation of medical records, clinical, tests, x-rays and evaluation and conclusions by: Osep E. Armagan, M.D.

Report Transcribed and Prepared by:	Osep E. Armagan, M.D.

By my signature on this report, I certify that this report represents the work product of myself and my staff in the manner described and expresses exclusively my professional opinion, findings and conclusions on the matter discussed in the report.

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

"I further declare under penalty of perjury that Ram Henares, Medical Records Coordinator, prepared a summary of records for the purposes of this report and I, Osep E. Armagan, M.D., performed the final review and analysis of the records."

Pursuant to Labor Code Section 5701 (a) (2), "I hereby declare under penalty of perjury that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referral of this evaluation or consultation. As such, there has not been a violation of Labor Code Section 139.3. I further declare under penalty of perjury that the contents of this report are true and correct to the best of my knowledge."

Dated and signed in the County of [redacted], State of California.

Very truly yours,

[redacted]

Osep E. Armagan, M.D.
Board Certified Orthopedic Surgeon
Fellow American Academy of
Orthopedic Surgeons

OEA/

cc: [redacted]

OSEP E. ARMAGAN, M.D.
A Professional Corporation

Diplomate American Board
of Orthopaedic Surgery

Sample IME Report #2

[redacted]

RE: :

Date of Birth: [redacted]
Date of Injury:
Date of Orthopedic Independent Medical Examination: [redacted]

Insurance Carrier:
Employer:
Claim Number: [redacted]

INDEPENDENT MEDICAL EXAMINATION
IN THE SPECIALTY OF ORTHOPEDICS

To Whom It May Concern:

This report has been prepared in accordance with Labor Code Section 5307.1 as a Complex Medical-Legal Evaluation with extraordinary circumstances ML 104, with modifier 94. The required complexity factors in this examination included at least three of the six factors listed under ML 103 as follows: face-to-face time of 2 hours, record review of 2 hours and 30 minutes, and physician's preparation of report of 2 hours with issues of medical causation and issues of apportionment discussed.

The above captioned patient is [redacted] year-old male who is seen today [redacted] per letter of transmittal dated [redacted] from, Examiner for AIMS regarding a specific injury on [redacted] with regards to his left shoulder, while he was employed as a Police Officer for the City of .

Mr. was seen and examined at my office on 50 North La Cienega Blvd., Suite # 215, Beverly Hills, CA 90211.

All parties denied a recent history of fever, chills, or contact with a known Covid-19 positive person. All parties involved were wearing masks and gloves. Non-contact Thermal temperature readings were normal of all parties involved.

HISTORY OF INJURY:

Mr. began employment as a Police Officer with the City of [redacted] in [redacted] Prior to his employment with the City of [redacted] he denied any injuries or pain, missing any time from work or seeking any medical care with regards to his left shoulder. He began as a Patrol office from [redacted] He worked 5 days a week, 40 hours per week, on a rolling schedule with occasional overtime and weekends. He reported he wears a Sam Browne Belt and a Kevlar vest every day. In [redacted] he was transferred to a School Resource team. He currently works Tuesday to Friday, from 7:00 am to 5:00 pm. During the summers, he worked on the Gang Unit. He stated he sustained a MVA while on the gang unit in [redacted] He was a passenger in the patrol car, and he sustained an injury to his lower back, a fracture of his left 5th finger and fractures of his left ribs. He underwent physical therapy. He reported that he did not hire an attorney and he did not receive a settlement. He was off work until [redacted]

When he returned, he stated he was performing his usual and customary duties without any injuries, or missing any time from work or seeking any medical care with regards to his left shoulder, until the date of his specific injury on [redacted] He stated he was using large bolt cutters to remove the lock from an illegal gambling facility. When he closed the jaws, he felt and immediate pop in his left lateral chest and arm. He reported the incident to his supervisor, and was referred to an urgent care for treatment that day. He was diagnosed with an injury to his left pectoralis tendon. He was evaluated by, M.D., and placed on temporary total disability and an MRI of the Left Shoudler and Chest were ordered. The MRI of the Chest without contrast from Radiology Medical Group, on [redacted] read by Dr., showed: High-grade partial tear and/or rupture of the left pectoralis major tendon with associated musculotendinous strain. He was referred to, M.D. at I Orthopedics on [redacted] and he was recommended to undergo a Surgical repair of his left pectoralis tendon. On [redacted] he underwent surgical repair of the pectoralis tendon. He underwent pos-operative physical therapy. He was returned to work full duty without restrictions on [redacted] His physical therapy ended 6 weeks ago. He has continued to perform his usual and customary duties up until the date of this exam on [redacted]

PAST MEDICAL HISTORY:

The patient denies a history of Diabetes, HTN, cancer, thyroid, liver, renal, GI upset, respiratory or heart problems.

Past Medical History:

[redacted] – slip and fall at one, sustained only seizure
Elevated cholesterol – dx 1 year ago

Medications:

Crestor 10 mg daily
Ibuprofen 200 mg – 2-3 times a week for pain in his left shoulder

Operations:

[redacted] – Left Shoulder pectoralis major sternal head repair to humerus
2013 – Appendectomy
Vasectomy, reversal, and vasectomy

Allergies: Dilantin

Social History:

He denied a history of smoking
He denied a history of alcohol use
He denied a history of marijuana or illicit drug use
He denied a history of military service

Family History:

Mother – deceased, [redacted] age [redacted], Alzheimers, DM, HTN, CHF
Father – deceased [redacted], age [redacted], infection, DM, HTN
Siblings – [redacted] healthy
Married –
[redacted] healthy

Previous Injuries:

He denied any sports related injuries

He described one any prior industrial injury MVA [redacted]

In the summer on the gang unit, he was a passenger in patrol chasing a suspect, which T-boned another car. He was taken to the Emergency room, and diagnosed with a back strain, left rib fractures and a fracture left 5ht finger, which was splinted. He underwent some physical therapy. He was off work until [redacted]

Prior Employment History:

Prior to his employment with the City of [redacted] he worked as a general manager/personal trainer for "from [redacted] He denied any injuries or pain, missing any time from work or seeking any medical care during that employment. Prior to that employment, he worked as a manager for from [redacted] He denied any injuries or pain, missing any time from work or seeking any medical care during that employment.

REVIEW OF MEDICAL RECORDS OF [redacted]:

[redacted] – Doctor's First Report of Occupational Injury or Illness by, FNP/, M.D. Date of injury [redacted] Employed by City of [redacted] – Risk Management as a [redacted] officer for 5 years. He is right-hand dominant. While at work, patient stated while cutting a locker with bolt cutters, he felt and heard a pop in his left shoulder and had pain to his left side of chest, anterior, and into pectoralis. Felt numbness and tingling that radiated down to his left arm. Rated the pain as 8/10. Moving around aggravates the pain and not moving it alleviates the pain. On examination, patient in moderate distress. Tenderness over anterior shoulder into lateral pectoralis and anterior axillary area. Unable to externally rotate past neutral. Decreased strength. Range of motion revealed left shoulder flexion 10 degrees, extension 0 degrees, and abduction 15 degrees. Diagnosis: Unspecified sprain of left shoulder joint, initial encounter. Toradol injection ordered. STAT MRI of the left shoulder ordered. Ibuprofen and Norco prescribed. Arm sling dispensed. Patient on total temporary disability.

[redacted] – MRI of the Left Shoulder without contrast from Medical Group, Inc. by [redacted] M.D. Findings include normal and no visible tendinitis or tear of the rotator cuff tendons; normal-appearing cuff muscles; no significant atrophy of tear of the deltoid muscle; and no abnormal signal, attrition or tear of the long biceps tendon. Normal and no visible labral tear or biceps anchor pathology of the superior labrum no visible tear or attrition of the anterior/inferior labrum/biceps anchor and no posterior labrum abnormality. No visible capsular laxity or thickening and a type I origin of the middle glenohumeral ligament. Normal acromioclavicular joint and ligaments. Normal coracoclavicular ligaments. Downward curvature of the acromion compatible with a type II configuration. No significant effusion of the subacromial bursa. No visible cartilage narrowing or focal defect. Normal proximal humerus, glenoid and coracoid. No other significant findings or glenohumeral effusion. Conclusion: 1) Type II configuration of the acromion without significant narrowing of the coracoacromial arch. 2) No rotator cuff tear or tendinosis. 3) No joint effusion or bursitis.

[redacted] – MRI of the Chest without contrast from Medical Group, Inc. by Dr.. Conclusion: High-grade partial tear and/or rupture of the left pectoralis major tendon with associated musculotendinous strain.

[redacted] – Primary Treating Physician's Progress Report by. Patient felt a little less constant pain. Pain rated at 6/10. Examination revealed patient in moderate distress with tenderness over anterior shoulder pectoralis and axillary region. Diagnosis: Unspecified sprain of left shoulder joint, subs encounter. Referred for STAT MRI for the pectoralis. Take medications as directed. Total temporary disability.

[redacted] – Primary Treating Physician's Progress Report by FNP /Dr.. Patient presented for MRI of pectoralis. Complained of a hard time sleeping due to pain. Left hand feels

tight and swollen. Examination revealed patient in moderate distress with tenderness to palpation and swelling over the anterior left shoulder and axillary area. Tenderness to palpation of biceps head. Ecchymosis over medial upper arm and axillae. Range of motion left shoulder flexion of 10 degrees, extension 10 degrees, abduction 40 degrees, and external rotation 10 degrees. Diagnosis: Unspecified sprain of left shoulder joint, subs encounter. Referred for STAT consult and treatment with a qualified orthopedist, Dr. Hamilton. Take medications as directed. Total temporary disability.

[redacted] - Work Status Summary from I Medical Group by FNP /Dr.. Temporarily off work from [redacted]

[redacted] – Initial Orthopedic Consultation Report and Preoperative Office Visit Report from [redacted] by, M.D. Date of injury [redacted] Employed by City of [redacted] as a police officer for 5 years. Job requirements include responding to scenes of accidents, crimes or other emergencies; drive his patrol car to and from various locations throughout the day; get in and out of the car repeatedly; pursue and restrain suspects; sit, walk, stand, run, jump, crawl, kneel, push and pull at various times; clear the streets of debris and assist motorists and victims as needed; and wear equipment including a gun and a vest which can weigh up to 25 pounds. Works 40 hours per week. While at work, cutting locks with bolt cutters, he felt a pop in his left shoulder when cutting his 3rd lock. Pain radiated down the arm to the fingertips and pectoral. Reported the injury to employer, was referred to Medical Group. Underwent x-rays and STAT MRI which revealed normal MRI of the left shoulder. Sent back for a STAT MRI of the pectoral which revealed a soft tissue tear. Chief complaint of left pectoral pain at 5/10 when at rest and 8/10 with any attempts of movements. Restricted range of motion. Swollen left pectoral and upper biceps. Difficulty getting dressed, putting on socks and shoes, doing housework, driving and sleeping through the night. Initial visit consult done per request of workcomp. Patient also came for discussion on upcoming surgery. Complained of significant pain and mechanical symptomatology in the shoulder, not improved with conservative treatment, and now requesting for surgical intervention. Examination revealed evidence of pectoralis major muscle rupture. Positive dropped nipple sign, retraction noted. Significant pain in the region of the pectoralis, tendon can be palpated. Moderate swelling. Moderate pain upon palpation mostly in the pectoralis region. Range of motion revealed forward flexion 130 degrees with pain, abduction 80 degrees with pain, external rotation 40 degrees with pain, and internal rotation to hip with pain. Strength revealed 4-/5 of the supraspinatus and infraspinatus, 3/5 of the subscapularis, all tested with pain. Positive cross-arm adduction test, Speed's test, and OBrien's test. Radiographs revealed bony architecture normal with humeral head centered with the glenoid; no fractures or abnormal calcification present. MRI reviewed with evidence of pectoralis major tear, sternal and clavicular head. Impression: 1) Left shoulder pectoralis major rupture. 2) Pre-op evaluation for open pectoralis tendon repair. Surgical exploration and repair recommended. Work capacity per primary treating physician.

[redacted] – Primary Treating Physician's Progress Report by /Dr. I. Patient reported no numbness to fingers unless prolonged use of the sling. Examination revealed patient in moderate distress. Tenderness to palpation and swelling of the anterior left shoulder. Tenderness on biceps head and axillary area. Decreased strength and ROM. Diagnosis: Unspecified sprain of left shoulder joint, subs encounter. Keep appointment with orthopedist. Take medications as directed. Total temporary disability.

[redacted] – Work Status Summary from I Medical Group by FNP [redacted] Dr.. Temporarily off work from [redacted]

[redacted] – Operative Report from I Surgery by. Preoperative diagnosis: Left pectoralis major tendon rupture. Postoperative diagnosis: Rupture of sternal head of pectoralis major tendon, left shoulder. Procedure is open repair of pectoralis tendon rupture.

[redacted] – Secondary Treating Physician's Progress Report from Dr.. Patient returned for first postop visit of the left shoulder status post open repair of left pectoralis tendon rupture. No symptoms of infection. Patient in a sling. Complained of feelings of tightness in his chest muscles but noticed pectoralis region is much more symmetrical. Examination revealed surgical incisions healing well. No signs of infection. Moderate swelling. Moderate pain to palpation. Range of motion not checked. X-rays revealed evidence of buttons within the pectoralis major insertion with good position of the inner cortical buttons. Alignment is otherwise excellent. Impression: Status post open repair of left pectoralis tendon rupture. Continue use of ice, heat, and medications as necessary. Continue with sling for 6 more weeks. Work status per primary treating physician.

[redacted] – Primary Treating Physician's Progress Report by FNP /Dr. Patient status post-surgery to left shoulder. Complained of loss of sensation to all 5 fingers to right hand, felt right hand swollen at times, comes and goes, currently wearing sleeve. Continued ibuprofen and Norco at times for pain. Finished antibiotics. Pain rated at 4/10. Examination revealed patient in moderate distress. Tenderness to palpation on the anterior region of the left shoulder, deltoid, biceps head, clavicular region, and axillary region. Diagnosis: Unspecified sprain of left shoulder joint, subs encounter. Take medications as directed. Keep appointment with orthopedist. Total temporary disability.

[redacted] – Work Status Summary from I Medical Group by FNP [redacted] /Dr. I. Temporarily off work from [redacted]

[redacted] – Primary Treating Physician's Progress Report (PR-2) by FNP /Dr. Patient stated Dr cleared him for therapy and is starting the next day. Still has constant pain. Pain rated as 5/10. Examination revealed patient in moderate distress. Tenderness to palpation with wound on the left anterior shoulder. Tenderness to palpation over the biceps head, AC joint, and axillary region. Decreased strength. Range of motion revealed left shoulder flexion 50 degrees, extension 35 degrees, abduction 45 degrees, adduction 0 degrees, and external rotation 25 degrees. Diagnosis: Unspecified sprain of left shoulder

joint, subs encounter. Start physical therapy. Take medications as directed. Keep appointment with orthopedist. Total temporary Disability.

[redacted] – Work Status Report from Medical Group by FNP [redacted] /Dr. . Temporarily off work from [redacted]

[redacted] – Daily Physical Therapy Notes from Physical Therapy Fitness, Inc. by, P.T. [redacted] P.T.A./, P.T./, P.T. Patient was seen approximately 12 times for his left shoulder. Treatment plan included therapeutic exercise, manual therapy, hot packs, ice packs, and PT evaluation.

[redacted] – Primary Treating Physician's Progress Report (PR-2) by FNP /Dr.. Patient stated no numbness and currently in therapy. Pain rated at 4.5/10. Examination revealed patient in moderate distress. Tenderness to palpation on the anterior left shoulder, biceps head, and axillary region. Decreased strength. Range of motion of the left shoulder revealed flexion 95 degrees, extension 25 degrees, abduction 65 degrees, adduction 25 degrees, and external rotation 30 degrees. Diagnoses: 1) Unspecified sprain of left shoulder joint, subs encounter. 2) Encounter for other specified surgical aftercare. Continue physical therapy. Take medications as directed. Keep appointment with orthopedist. Return to work modified duty.

[redacted] – Work Status Summary Report from Medical Group by FNP [redacted] /Dr. Return to work with left shoulder restrictions of limited use; no repetitive use and no overhead work; lifting, pushing, or pulling limitations up to 5 pounds; office type work only; and no confrontation work from [redacted]

[redacted] – Primary Treating Physician's Progress Report (PR-2) by FNP /Dr.. Patient has completed therapy and is awaiting for additional therapy. No numbness. Pain rated at 2-3/10. Examination revealed patient in mild distress. Tenderness to palpation in the axillary region. Range of motion revealed left shoulder flexion of 130 degrees, extension 40 degrees, abduction 95 degrees, adduction 40 degrees, and external rotation 35 degrees. Diagnoses: 1) Unspecified sprain of left shoulder joint, subs encounter. 2) Encounter for other specified surgical aftercare. Take medications as directed. Keep appointment with orthopedist. Return to work modified duty.

[redacted] – Work Status Summary Report from Medical Group by FNP /Dr. Return to work with restrictions for the left shoulder of limited use, no repetitive use and no overhead work; lifting, pushing, or pulling limitations up to 5 pounds; office type work only; and no confrontational work from [redacted]

[redacted] – Primary Treating Physician's Progress Report (PR-2) by FNP /Dr. Patient stated he was released to full duty by Dr.. Pain rated at 0-3/10. Examination revealed patient in mild distress. Left shoulder with tenderness to palpation on the biceps head and axillary region. Decreased strength. Range of motion revealed left shoulder flexion 155 degrees, extension 40 degrees, abduction 150 degrees, adduction 35 degrees, and

external rotation 45 degrees. Diagnoses: 1) Unspecified sprain of left shoulder joint, subs encounter. 2) Encounter for other specified surgical aftercare. Return to work full duty.

[redacted]- Work Status Summary Report from Medical Group by FNP /Dr.. Return to work without restrictions from [redacted]

The report by, FNP and, M.D. dated [redacted] was listed in the medical index but was not included in the stack of records.

There were also miscellaneous records and non-orthopedic reports including cover letters, medical index page, intraoperative nursing record and anesthesia record, and regional anesthesia procedure note pages.

PRESENT COMPLAINTS:

His primary area of complaint is his left shoulder. He stated it bothers him every day, frequently at a baseline level of 6-7/10. He stated it does not lock, sublux, but does feel weak. He described aggravation with motions above his shoulder height. He described aggravation with lifting/carrying and pushing/pulling. He described radiating pain to his elbow. He described occasional radiating numbness down his arm. He underwent an MRI of the left shoulder on [redacted]– MRI of the Left Shoulder without contrast from [redacted]Radiology Medical Group Inc. on [redacted] read by, M.D., which showed: 1) Type II configuration of the acromion without significant narrowing of the coracoacromial arch. 2) No rotator cuff tear or tendinosis. 3) No joint effusion or bursitis. He underwent an MRI of the Chest without contrast from Medical Group, Inc., on [redacted] read by Dr.., which showed: High-grade partial tear and/or rupture of the left pectoralis major tendon with associated musculotendinous strain. He underwent open surgical repair of a rupture of the sternal head of the pectoralis major off his left humerus on [redacted] He underwent physical therapy. He returned to work full duty on [redacted] He stated his left shoulder is 50 % improved since his surgery. He last underwent physical therapy 6 weeks ago.

ACTIVITIES OF DAILY LIVING:

Regarding Activities of Daily Living (Fifth Edition, AMA Guides, page 4, table 1-2), Under Self-Care Personal Hygiene, he reported a 3 out of 5 level of difficulty with his ability to bath himself and dress himself, a normal 1 out of 5 level of functioning with his ability to urinate, defecate, brush his teeth, comb his hair, and eat by himself. Under Communication Skills, he reported a 2 out of 5 level of difficulty with his ability to type, and a normal 1 out of 5 level of functioning with his ability to write, see, hear, and speak. Under Physical Activities, he reported a 2 out of 5 level of difficulty with his ability to sit, recline, walk, and go up and down stairs and a normal 1 out of 5 level of functioning with his ability to stand. Under Sensory Function, he reported a 2 out of 5 level of difficulty with

his ability to feel, a normal 1 out of 5 level of functioning with his ability to hear, see, taste, and smell. Under Hand Activities, he reported a 4 out of 5 level of difficulty with his ability to grasp or grip, lift, and manipulate small items. Under Travel, he reported a 3 out of 5 level of difficulty with his ability to ride in a car or bus, drive a car or travel by plane. Under Restful Night Sleep Pattern, he reported a 4 out of 5 level of difficulty. Under Sexual function, he reported a 3 out of 5 level of difficulty. This form was signed by Charles Pratt on [redacted]

Under Questions Concerning Activities of Daily Living, he reports self-care activities are done normally but with extra discomfort. He reported he can only lift and carry light to medium objects. There is no change in his ability to walk. He reported the most strenuous level of activity he can do for at least 2 minutes is moderate activity. He can climb 1 flight of stairs with some of difficulty. He can only sit between 1 – 2 hours at a time. He can stand or walk without any time limitations. He has some difficulty reaching and grasping something off a shelf at chest level. He is a lot of difficulty reaching and gasping something off a shelf overhead. He can push or pull light objects. He has a lot of difficulty with gripping, grasping, holding, and manipulating objects with his hands. He has some difficulty with repetitive motion such as typing on a computer. He has a lot of difficulty with forceful activities of his arms and hands. He has a lot of difficulty with kneeling, bending, or squatting. He stated his sleep is moderately disturbed. No sexual function because of injury. In regards to his pain at the moment, he stated his pain is mild at the moment. In regards to his pain most of the time, his pain is moderate most of the time. His injury and/or pain interferes with his ability to travel some of the time. His injury and/or pain interferes with his ability to engage in social activities some of the time. His injury and/or pain interferes with his ability to engage in recreational activities some of the time. His injury and/or pain interferes with his concentrating and thinking a lot or most of the time. His injury and/or pain has caused emotional distress with depression and anxiety a lot of the time. He reported a moderate change with typing, mild change with writing and no change with seeing, hearing and speaking. His pain level on the average during the past week was a 5 out of 10 and his pain level at its worst over the past week was an 7 out of 10, primarily related to his left shoulder. This form was signed by [redacted] on [redacted]

Regarding Activities of Daily Living, per table 18-4, Ratings Determining Impairment Associated with Pain, he had a score of 31 points. This form was signed by [redacted] on [redacted]

PHYSICAL EXAMINATION:

Physical examination reveals a well-developed, well-nourished, middle-aged male in no acute distress. He is [redacted] tall and his weight is [redacted] pounds which is stable.

Vital Signs:

Temp:	93 F, noncontact forehead
BP:	135/85
Pulse:	74

Sensation is tested with the wooden shaft of a cotton swab. The patient described equal and symmetric bilateral sensation on the lateral and medial aspects of his upper arms, equal sensation on the lateral and medial aspects of his forearms, and equal sensation on the dorsum and volar aspects of his hand. Two-point discrimination is intact at 5 mm or less throughout the fingertips and thumbs of both hands.

Motor Examination of the Upper Extremities:

	Left	Right
Shoulder Flexion:	4/5	5/5
Shoulder Extension:	5/5	5/5
Shoulder Abduction:	5/5	5/5
Shoulder Adduction:	4/5	5/5
Shoulder External Rotation:	5/5	5/5
Shoulder Internal Rotation:	4/5	5/5
Elbow Flexion:	5/5	5/5
Elbow Extension:	5/5	5/5
Forearm Pronation:	5/5	5/5
Forearm Supination:	5/5	5/5
Wrist Flexion:	5/5	5/5
Wrist Extension:	5/5	5/5
Radial Deviation:	5/5	5/5
Ulnar Deviation:	5/5	5/5
Thumb Flexion:	5/5	5/5
Thumb Extension:	5/5	5/5
Thumb Abduction:	5/5	5/5
Thumb Adduction:	5/5	5/5
Thumb Opponens:	5/5	5/5
Finger Flexion:	5/5	5/5
Finger Extension:	5/5	5/5
Finger Abduction:	5/5	5/5
Finger Adduction:	5/5	5/5

Reflexes:

	Left	Right
Biceps:	+1	+1
Triceps:	+1	+1

Brachioradialis:	+1	+1

Arm Circumference Measurements:

	Left	Right
Arm above the elbow:	38.5 cm	39.0 cm
Forearm:	31.5 cm	31.5 cm
Wrist:	18.0 cm	17.5 cm

Mr. [redacted] is right-handed.
Grip Strength Testing, Jamar Dynamometer:

	Left	Right
Trial 1:	42 kg	52 kg
Trial 2:	48 kg	54 kg
Trial 3:	42 kg	46 kg

Shoulders

On Inspection, there is an "A shape pointed" deformity of the left axillary fold compared with the "U shape" of the right axillary fold. There is a 6 cm delto-pectoral incision over the left upper arm. The incision is well healed, with some adherence to the underlying tissues, and with localized paresthesias.

On Palpation of the left shoulder, there is tenderness over the bicipital groove, but no tenderness over the AC joint, subacromial space or posteriorly. On Palpation of the right shoulder, there is no tenderness over the AC joint, bicipital groove, subacromial space or posteriorly. There is no spasm or tightness noted.

Range of Motion of the Shoulders:

	Left	Right
Flexion:	145,140,145 deg	180,180, 75 deg
Extension:	35,35,30 deg	45,50,45 deg
Abduction:	155,150,165 deg	175,170,175 deg
Adduction:	25,20,25 deg	35,40,40 deg
External Rotation:	70,65,65 deg	75,80,75 deg
Internal Rotation:	45,45,40 deg	80,80,75 deg

Special Tests:

	Left	Right
Apprehension test:	Negative	Negative
Impingement test:		
Neer test:	Negative	Negative
Hawkins test:	Negative	Negative

X-RAYS:

Chest Xray: No calcification within the left pectoralis major tendon. Inferior level of pectoralis muscle mass is symmetric.

3 Views of Left Shoulder: AP, internal, external and abduction views of both shoulders are obtained. In the left shoulder, the glenohumeral and AC joints are intact. There are no fractures or dislocations noted. There are 2 endo-buttons noted in the medial proximal humeral cortex. The left axillary fold creates an "A shadow".

3 Views of the Right Shoulder: In the right shoulder, the glenohumeral and AC joints are intact. There are superior osteophytes noted over the AC joint. There are no fractures or dislocations noted. The right axillary fold creates an "U shadow".

IMPRESSION AND COMMENT:

Mr. began employment as a [redacted] Officer with the City of [redacted] in [redacted] Prior to his employment with the City of [redacted] he denied any injuries or pain, missing any time from work or seeking any medical care with regards to his left shoulder. He stated he was performing his usual and customary duties without any injuries, or missing any time from work or seeking any medical care with regards to his left shoulder, until the date of his specific injury on [redacted] He stated he was using large bolt cutters to remove the lock from an illegal gambling facility. When he closed the jaws, he felt and immediate pop in his left lateral chest and arm. He reported the incident to his supervisor, and was referred to an urgent care for treatment that day. He was diagnosed with an injury to his left pectoralis tendon. He was evaluated by, M.D., and placed on temporary total disability and an MRI of the Left Shoudler and Chest were ordered. The MRI of the Chest without contrast from Medical Group, on [redacted], read by Dr., showed: High-grade partial tear and/or rupture of the left pectoralis major tendon with associated musculotendinous strain. He was referred to, M.D. at I Orthopedics on [redacted] and he was recommended to undergo a Surgical repair of his left pectoralis tendon. On [redacted], he underwent surgical repair of the pectoralis tendon. He underwent post-operative physical therapy. His physical therapy ended 6 weeks ago. He was returned to work full duty without restrictions on [redacted]

He has continued to perform his usual and customary duties up until the date of this exam on [redacted]

Diagnoses

1. Left Shoulder sprain and strain – s/p Left Pectoralis Major repair on [redacted]

I do believe Mr. is **Permanent and Stationary** and has reached **Maximum Medical Improvement** as of the date of this exam on [redacted]

Work Restrictions

For his left shoulder, I would limit him from prolonged work with his arm above his shoulder height.

I would allow Mr. to continue to work full duty as a Police Officer, as he has been since [redacted]

Future Care

For his left shoulder, I would recommend a course of physical therapy, 2 times a week for 6 weeks, to include iontophoresis over the scar to loosen and desensitize the scar tissue, and to instruct him on a home strengthening and stretching program.

Industrial Causation

I do believe there is industrial causation with regards to his left shoulder, while he was employed as a Police Officer for the City of [redacted]

Apportionment

Mr. began employment as a [redacted] Officer with the City of [redacted] in [redacted] Prior to his employment with the City of [redacted] he denied any injuries or pain, missing any time from work or seeking any medical care with regards to his left shoulder.

I would apportion 100 % of his left shoulder disability to his specific injury on [redacted] while he was employed as a [redacted] Officer for the City of [redacted]

Impairment Ratings

Orthopedic Impairment is per the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition.

For his left shoulder, the loss of motion is per fig. 16-40, on page 476, fig. 16-43, on page 477, and per fig. 16-46, on page 479. His flexion of 145 deg, gives 2.5 % UE, extension of 35 deg, gives 1 % UE, his abduction of 155 deg, gives 1 % UE, adduction of 25 deg, gives 1 % UE, external rotation of 70 deg, gives 0 % UE, and internal rotation of 45 deg, gives 2.5 % UE, for a total of 8 % UE. This converts per table 16-3, on page 439 to 2 % WPI for his left shoulder.

The loss of strength for his left shoulder is per table 16-35 on page 510. His grade 4/5 strength for his shoulder flexion provides a rating of 1-6 % UE. I would give a rating of 3 % UE. His 4/5 abduction strength provides a rating of 1-3 % UE. I would give a rating of 2 % UE, and his 4/5 strength of internal rotation provides a rating of 0-2 % UE. I would give a rating of 1 % UE, for a total of 6 % UE.

In Summary, his 8 % UE for his loss of motion, combines with his 6 % UE for his loss of strength, to give 14 % UE. This converts per table 16-3, on page 439, to 8 % WPI. When evaluating his ratings determining impairment associated with pain, from 18-4, on page 576, he has a score of 31 points, which corresponds to a moderate impairment per table 18-7, on page 584, for which I would add 2 points for pain. This provides a 10 % WPI for his left shoulder. I believe this to be an accurate rating of his impairment.

I should like to thank the board and parties involved for the opportunity of evaluating Mr. as Orthopedic Independent Medical Examiner.

If there are additional questions, I would be happy to answer interrogatories. Should cross examination become necessary, I respectfully request it be done by deposition in this office.

DISCLAIMERS:

In compliance with the WCAB Rule #10978, Labor Code Section 4628, and AB 3660, the following information is furnished:

History is taken by: Osep E. Armagan, M.D.

History is reviewed with the patient and edited by: Osep E. Armagan, M.D.

Physical Examination performed and recorded by: Osep E. Armagan, M.D.

X-rays taken by: [redacted]

Recorded by: Osep E. Armagan, M.D.

Interpretation of medical records, clinical, tests, x-rays and evaluation and conclusions by: Osep E. Armagan, M.D.

Report Transcribed and Prepared by: Osep E. Armagan, M.D.

By my signature on this report, I certify that this report represents the work product of myself and my staff in the manner described and expresses exclusively my professional opinion, findings and conclusions on the matter discussed in the report.

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

"I further declare under penalty of perjury that Ram Henares, Medical Records Coordinator, prepared a summary of records for the purposes of this report and I, Osep E. Armagan, M.D., performed the final review and analysis of the records."

Pursuant to Labor Code Section 5701 (a) (2), "I hereby declare under penalty of perjury that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referral of this evaluation or consultation. As such, there has not been a violation of Labor Code Section 139.3. I further declare under penalty of perjury that the contents of this report are true and correct to the best of my knowledge."
Dated and signed in the County of Los Angeles, State of California.

Very truly yours,

Osep E. Armagan, M.D.
Board Certified Orthopedic Surgery
Fellow American Academy of
Orthopedic Surgeons

OEA/

cc: [redacted]

December 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: January 4, 2023 Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
JESSE CARR, M.D. – PSYCHIATRY

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Jesse Carr, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

Jesse Carr, M.D. is Board Certified in Psychiatry. He received his medical degree from Howard University in 1987 and completed an internship and residency at the University of Southern California in 1991. Dr. Carr has 5 years of experience performing independent medical and medical legal evaluations for both public and private organizations.

Upon approval to the panel, LACERA will conduct a virtual orientation with DRS staff, legal counsel and the physician and his management team to provide a comprehensive overview of the LACERA Panel Physician Guidelines, requirements, and protocols to ensure a thorough understanding of the Rules in Evaluating Applicants, Disability Retirement Law Standards, and what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff will also cover report submission timeframes, fee schedule and billing procedures. Additional diagnostic testing request protocols; medical license, Board Certification, and insurance coverage requirements. Lastly, we will provide an overview of the Quality Control Questionnaire process and procedures.

On December 21, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Jesse Carr, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Jesse Carr, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

/TLC

LACERA
Los Angeles County Employees Retirement Association
300 N. Lake Ave., Pasadena, CA 91101 ■ Ma to : PO Box 7060, Pasadena, CA 91109-706 626/564-6132 • 800/786-6464

APPLICATION TO LACERA PANEL OF EXAMINATION PHYSICIANS

ALL APPLICANTS MUST SUBMIT THE FOLLOWING WITH THEIR APPLICATION

- Current Curriculum Vitae
- Two (2) **Sample" Medical Reports** – Must be Redacted
- Copy of Medical License
- Copy of Board Certification(s) – Applicant must be board certified to qualify for panel
- Certificate of Insurance

GENERAL INFORMATION **Please attach a list of any additional locations.**	Date Jan 20, 2022
Phys c an Name: Jesse Carr,MD	Group Name: Consultative Examination Services, Inc.
Pr mary Address: 2810 E. Del Mar blvd. Suite 4, Pasadena CA 91107	
Pr mary Contact: Moses Hernandez	T t e: CEO
Te ephone: (626) 513-0415 Fax: (626) 513-4095	Ema : client@iamces.com
Secondary Address: N/A	
Te ephone: (626) 513-0415 Fax: (626) 513-4095	Ema : client@iamces.com

PHYSICIAN BACKGROUND	
F e d of Spec a ty: Psychiatry Board Cert f cat on ☒Yes ☐No	Subspec a ty: Board Cert f cat on ☐Yes ☒ No
L cense # Go65663 Exp rat on Date: 04/20/23	
Has your cense been suspended n the ast 3 years? ☐Yes ☒No Has there been any d sc p nary act ons f ed aga nst you n the ast 3 year? ☐ Yes ☒ No	

EXPERIENCE AND CURRENT PRACTICE
Indicate the number of years of experience that you have in each category and the time spent performing each activity.

Type	Number of Years	Current Practice	Time Spent (%)
AME	0	Treatment	50
IME	5	Eva uat ons	10
QME	0	Research	40
Workers' Compensation Eva uat ons	0	Teach ng	0
D sab ty Eva uat ons	5		100 %
Med-Lega Reports	5		

Perform ng Med ca Eva uat ons for Pub c Organ zat ons	☒ Yes ☐ No
Perform ng Med ca Eva uat ons for Pr vate Organ zat ons	☒ Yes ☐ No
P ease Names of Organ zat ons:	

Est mated T me from Appo ntment to Exam nat on: ☐ 2 weeks ☒ 3-4 Weeks ☐ Over a month	Ab e to Subm t a F na Report and Invo ce n 30 days: ☒ Yes ☐ No

LACERA FEE SCHEDULE	
Phys ca Exam and In t a Report	$2,015.00 + Add t ona Fee for Rev ewed Records* (see Rev ew of Record rate)
Record Rev ew On y and In t a Report	$1,007.50 + Add t ona Fee for Rev ewed Records* (see Rev ew of Record rate)
Psych atr c/Psycho og ca Exam nat on (n off ce) and In t a Report*	$ 4, 030.00 + Add t ona Fee for Rev ewed Records* (see Rev ew of Record rate)
Psych atr c/Psycho og ca Exam nat on (no exam) and In t a Report*	$ 2,015.00 + Add t ona Fee for Rev ewed Records* (see Rev ew of Record rate)
Tox co ogy and Onco ogy Exam nat on (n off ce) and In t a Report*	$ 3,022.50 + Add t ona Fee for Rev ewed Records* (see Rev ew of Record rate)
Tox co ogy and Onco ogy Exam nat on (no exam) and In t a Report*	$ 1,511.25 + Add t ona Fee for Rev ewed Records* (see Rev ew of Record rate)
*Rev ew of Records (by Phys c an)	$ 455.00 per nch (LACERA w pay up to 1 hour of record-rev ew per nch of med ca records)
*Rev ew of Records (by Nurse)	$ 75.00 per nch (LACERA w pay up to 1 hour of record-rev ew per nch of med ca records)
Supp ementa Report	$ 455.00 per hour
Supp ementa Report when Pane Phys c an Gu de nes were not fo owed	No charge

Other Fees	
Adm n strat ve Hear ng Preparat on	$ 455.00 per hour
Depos t ons	$ 455.00 per hour w th 2 hours m n mum
Expert W tness n Super or or Appe ate Court	$3,500 – Ha f Day
Expert W tness n Super or or Appe ate Court	$7,000 – Fu Day

Cancellation Policy and Fees
Please indicate your cancellation policy and any applicable fees.

What s you Cance at on Po cy? (Attach po cy, f app cab e).

Must have 2 bus days' notice, in writing, for cancellation of IMEs. No show fee is same as cancellation fee.

Must have 5 business days' notice, in writing, for cancellation of hearings

Cance ed Exams that do not adhere to your stated po cy:	Fee: $ 50% of examination fees above
Cance ed Hear ngs that do not adhere to your stated po cy:	Fee: $ 50% of depo or Witness fees above.

Name of person comp et ng th s form:

Pr nt Name:	T t e:
Jesse Carr,MD	Psychiatrist
Phys c an S gnature: Jesse Carr,MD (Jan 20, 2022 10:30 PST)	Date Jan 20, 2022

You may attach additional pages if necessary.

Rev sed: 12/8/21

Jesse M. Carr, MD

CARR TREATMENT CENTER
License number: G065663
DEA Number: BC 1860914
2810 E. Del Mar Blvd. #4
Pasadena, Ca 91107
Phone: 626-449-6500
Fax: 626-449-6503
Email: jessecarrmd@yahoo.com

Education:

7/1987- 7/1991	University Of Southern California, Los Angeles, CA Internship and Residency, Psychiatry
5/1993	Board Certification- American Board of Psychiatry & Neurology
7/1983- 7/1987	Howard University, College of Medicine, Washington, D.C.- MD degree
9/1979- 6/1983	Loma Linda University, Riverside, CA- BS degree in Chemistry

Research and Professional Experience:

~7/2014- Present	BHC Alhambra Hospital, Rosemead, CA- Principal Investigator for BRS
~7/2013- Present	Aurora Las Encinas Hospital, Pasadena, CA- Principal Investigator for BRS
~7/2006- Present	Behavioral Research Specialists, LLC, Glendale, CA- Owner & Principal Investigator/Medical Director
~7/2000- 9/2016.	Partial Hospital Program, Glendale Adventist Medical Center- Medical Director
~7/2000- 7/2005	California Clinical Trials, Glendale, CA- Principal Investigator
~7/1998- 7/2000	Afflilated Reasearch Institute, Pasadena & Clairemont, CA- Principal Investigator
~1/2000- 1/2001	Las Encinas Hospital, Pasadena, CA- Chief of Staff
~1/1999- 1/2000	Las Encinas Hospital, Pasadena, CA- Vice Chief of Staff

~1/1997- 1/1999	Dual Diagnosis Program, San Gabriel Valley Medical Center- Medical Director
~7/1997-7/1999	Geriatric Resources, Inc., Pasadena, CA- Vice President of Research and Development
~1/1997- 1/1998	Partial Hospital Program, Corona Regional Medical Center- Medical Director
~1/1996- 1/1997	Elders Program, San Gabriel Medical Center- Medical Director
~1/1995- 1/1996	Partial Hospital Program, Ingleside Hospital, Rosemead, CA- Medical Director
~7/1994- 7/2016	Psycho-geriatric Consultant Services, El Monte, CA- Medical Director
~7/1993- 7/2005	Partial Hospital Program, Doctor's Hospital of W. Covina, CA- Medical Director
~7/1993- 7/1994	Intensive Outpatient Program, CPC Alhambra Hospital, Rosemead, CA- Medical Director
~1/1992- 1/1995	Utilization Review, Ingleside Hospital, Rosemead, CA- Medical Director
~1/1990- 1/1991	Utilization Review & Quality Assurance, Ingleside Hospital, Rosemead, CA- Medical Director (NOTE: Dr. Carr was self-employed in private practice, seeing patients for the entire 29 years of his career).

Clinical Trials:

Completed over 100 clinical trials as Principal Investigator (available on request)

Current Hospital Afflilations:

BHC Alhambra Hospital, Rosemead, CA

Glendale Adventist Medical Center

Other Professional Activities:

Member, Blue Cross Task Force

Bristol-Myers Squibb Opinion Leader

Board Certification and Faculty Appointment

JESSE CARR, M.D.
Diplomat in Psychiatry of the American Board of Psychiatry and Neurology
2810 E Del Mar Boulevard, Suite 4
Pasadena, CA 91107

[redacted]

QTC Medical Services
924 Overland Court,
DOL Services,
San Dimas, CA 91773-1742

RE: xxx
CL#: xxx
DOB: xx/xx/xxxx
Employer: xxx
Occupation: xxx

SECOND OPINION EXAMINATION

To Whom It May Concern:

Pursuant to the request of your department, a complete Psychiatric Evaluation was performed at my office, in person. Her daughter accompanied her to serve as an interpreter. I discussed with the claimant and her daughter the non-confidential nature of this examination and that the findings of this report will be disclosed to a third party and no doctor-patient relationship was established. I verified her identity looking at her identification.

GENERAL OBSERVATION:

The claimant is a xx-year-old female who is widowed. She arrived on time. She was appropriately dressed. She had good posture, but she was a sub-optimal historian. She was cooperative but was not able to answer simple questions. Her daughter reports that she has been diagnosed with an atypical Alzheimer's disease and has difficulty with her speech. Often times she is confused and needs complete assistance with ADLs.

CHIEF COMPLAINT:

According to the Statement of Accepted Facts, the claimant submitted a CA-2, Notice of Occupational Disease, stating that as a result of performing repetitive work activities over a prolonged period, she developed pain, numbness, and tingling in her wrists and weakness in her shoulders. The assigned date of injury for this occupational disease claim was [redacted]

[redacted]. Accepted conditions for this claim are bilateral carpal tunnel syndrome; bilateral medial epicondylitis; disorder of the bursae and tendons in the bilateral shoulder region; lesion of the ulnar nerve, right; other affections of the shoulder region, not otherwise classified, right; lesion of the radial nerve, right; sprain of the right wrist; sprain of neck; brachial neuritis or radiculitis not otherwise specified; fracture of one or more of the phalanges of the foot, open, right; displacement of cervical intervertebral discs without myelopathy; adjustment disorder with mixed anxiety and depressed mood; and other psychogenic pain. The claimant stopped working on [redacted] and has not returned to duty. It is also reported that she retired and moved to xxx in [redacted]

HISTORY OF PRESENT ILLNESS:

The claimant is unable to answer any questions about her past history. However, her daughter reports that she had some periods of anxiety while she was working and had some treatment with medication called Neurontin with unclear results for some periods of depression but had multiple work-related injuries according to the Statement of Accepted Facts. It is unclear if the claimant had a psychiatric history prior to the injuries on the job.

The claimant was diagnosed with Alzheimer's disease in [redacted] with speech disturbances, confusion, and memory problems. She has had an episode of wandering. She needs complete assistance with ADLs, but according to the daughter, has not been in any distress. There is no apparent pain. She does have bowel issues. Sometimes, she has to wear diapers. She does talk to herself in the mirror, but this does not appear to cause any distress. She is often laughing with herself. Her daughter feels that she is kind of keeping herself company. The daughter reports no sleep or appetite disturbances. Energy level seems to be fine. She does watch television but does not appear to be aware of what is going on or able to comprehend the content of any television program. The daughter reported that the claimant's husband passed away approximately in [redacted] and then she had significant depression. It seemed to be more than an abnormal grief reaction and that is when she was started with treatment with Zoloft, approximately 50 mg per day. Subsequently, Remeron was added, which helped with sleep and emotions. This was added in [redacted] and that seemed to help as well. She has been on Aricept for Alzheimer's disease as of [redacted].

REVIEW OF RECORDS:

- Reviewed the Statement of Accepted Facts dated [redacted].
- Reviewed the FECA Definitions of Causation.
- Reviewed the Work Capacity Evaluation of Psychiatric Conditions Form which is complete and attached to this report.

- Operative Report dated [redacted]. Operative arthroscopy, right shoulder. Subtotal synovectomy. Debridement, biceps tendon, articular surface rotator cuff and glenoid labrum. Bankart labral repair with Mitek bioabsorbable anchors x3. Subacromial bursoscopy. Coracoacromial ligament resection. Subacromial decompression. Mini-arthrotomy. Mumford procedure. Insertion on pain catheter. Application of surface electrodes. Microscopic right carpal tunnel release. Extra neural neurolysis. Application short arm posterior molded splint.

- Operative Report dated [redacted]. Arthroscopy right radiocarpal joint. Debridement of TFCC. Wafer procedure, right ulna. Application of pain pump and cold unit.

- Operative Report dated [redacted]. Right wrist diagnostic arthroscopy.

- Operative Report dated [redacted]. Operative arthroscopy, left shoulder. Partial synovectomy. Extensive debridement glenoid labrum biceps sheath and articular full thickness rotator cuff tear. Labral repair Bankart lesion with Arthrex bioabsorbable anchors x2. Arthrotomy left shoulder. Mumford procedure. Coracoacromial ligament resection. Acromioplasty. Subacromial decompression. Repair of rotator cuff tear, full thickness. Local injection of 10 cc of Marcaine, 10 cc of Duramorph. Insertion of indwelling pain catheter.

- Operative Report dated [redacted]. Anterior discectomy C5-6 and C6-7. Osteotomy anterior body of C5 and C6. Anterior osteotomy C6 and C7. Anterior arthrodesis C5-6 and C6-7. Insertion of Mosaic Peek C5-6. Insertion of Mosaic anterior Peek cage C6-7. Anterior stabilization C5 through C7. Insertion of bone graft material C5-6 and C6-7.

- Second Opinion Examination by Dr. [redacted], MD dated [redacted]. Diagnoses were major depressive disorder related to medical condition ongoing and chronic pain disorder related to medical condition, chronic, ongoing.

- Annual Exam dated [redacted] by Dr. [redacted], MD, internal medicine. Diagnosis of right carpal tunnel syndrome.

- Second Opinion Examination by Dr. [redacted], MD, orthopedic surgeon, dated [redacted]. Diagnoses were Alzheimer's problems and status post carpal tunnel release.

WORK HISTORY:

The claimant's daughter reports that the claimant worked for the xxx for 14 to 15 years. She reports that her mother was a biologist in her country of [redacted]. She came to the U.S. in [redacted]. She retired in [redacted]

FAMILY, SOCIAL AND ENVIRONMENTAL HISTORY:

The claimant is a xx-year-old female. She is widowed. She is currently living with her daughter and her brother. She has not been working since [redacted].

She is a college graduate and worked as a biologist in her country of [redacted]

There is no substance use disorder history.

No family history of any psychiatric conditions elicited.

LEGAL HISTORY:

No legal history reported.

MEDICAL HISTORY:

The daughter reports that the claimant had breast cancer in about [redacted] She had a lumpectomy. She had no radiation or chemotherapy at that time. Also, she has a history of hypercholesterolemia. She has had several surgeries as noted above in the review of records.

PSYCHIATRIC HISTORY:

The claimant had no previous psychiatric hospitalizations or previous psychiatric treatment, other than treatment with Neurontin for some anxiety. It is unclear if the claimant saw a psychiatrist and/or a therapist in the past.

CURRENT SYMPTOMS:

The daughter reports that currently the claimant is sleeping well. Appetite is adequate. Energy level seems to be fair. Her mood seems to be pleasant. There is no significant change in her weight and/or diet. She is unable to answer questions adequately. She is unable to identify a pen or a watch. She is not able to state the date or the day of the week. She is unable to remember three words when given to her immediately, but she reports that she is in good spirits and that she is not in any discomfort. She has no apparent suicidal or homicidal ideation. She has no apparent auditory or visual hallucinations or delusions.

CURRENT MEDICATIONS:

Current medications include Zoloft 50 mg per day, Remeron, and Aricept.

ACTIVITIES OF DAILY LIVING:

The claimant is unable to describe what a typical day would be like for her. She is not able to do any household chores or run errands. She is not able to cook or do light cleaning. She needs help with her grooming and with going to the bathroom. She needs complete assistance with ADLs.

MENTAL STATUS EXAMINATION:

APPEARANCE, ATTITUDE, AND BEHAVIOR: The claimant appeared to be cordial. She had good eye contact. She attempted to be cooperative. She attempted to answer questions, but answers were a mixture of some type of cross between Spanish and English, but mostly the answers were confused and did not make sense and were not appropriate to the questions that were asked.

SPEECH: She has normal rate and tone, but it was unintelligible.

INTELLECTUAL FUNCTIONING: Intellectual functioning appears to be below average, assessed by her inability to tell the examiner the day of the week or the date. She was completely disoriented. She could not tell the examiner the name of her daughter. She only knew her own first name but not her last.

MOOD AND AFFECT: Mood appears to be cordial and in no apparent distress. Affect was appropriate to mood. The daughter reports that she does feel an emotional connection to her, although she does not necessarily know who she is. There was no psychomotor agitation. No suicidal or homicidal ideations elicited.

THOUGHT PROCESSES: The claimant was disorganized and confused.

THOUGHT CONTENT: The claimant was easily distractible. The examiner was unable to elicit any paranoia or delusions. There are no apparent auditory, visual, or tactile hallucinations.

MEMORY AND CONCENTRATION: The claimant's concentration was limited. She was easily distracted. Her memory was completely impaired. She was disoriented to person, place, and date. She is not able to recall three out of three words immediately or five minutes later. She is not able to spell the word "world" backward. She was unable to do serial 7s.

FUND OF KNOWLEDGE: Fund of knowledge was impaired. She was not able to name the last three Presidents of the United States.

INSIGHT AND JUDGMENT: Insight and judgment were limited. She was not able to answer simple questions. She was disoriented to what was going on, but her behavior was cooperative.

DIAGNOSES BY DSM-V:

Major Neurocognitive Disorder, probable Alzheimer's disease (F02.80).

QUESTIONS FOR THE SECOND OPINION EXAMINATION PHYSICIAN:

1. **Summarize the history of illness/onset of illness.**

   The claimant apparently had a number of physical injuries secondary to repeated work-related injuries with some resultant periods of anxiety and depression. Psychiatric diagnosis is not clear, although she did get some treatment at that time with psychiatric medication, Neurontin. From the previous records, it appears that she had periods of significant depression, especially in [redacted] after the death of her husband and was treated with anti-depressants that were of benefit, so there may have been a major depressive disorder, but it does not appear to be present currently or it is currently in remission.

2. **Summarize social and family history, if applicable.**

   Please see Family, Social and Environment History.

3. **Review any non-industrial stress situations and evaluate their contribution, if any, to the claimant's condition.**

   In terms of non-industrial stressful situations prior to the work-related injury, they are not clear or elicited. The claimant is not able to contribute to what happened at that time. The daughter does not recall any specific non-work-related stressors at that time, although it had been difficult for the claimant making the adjustment to working for the post office given that she was a biologist in her country.

4. **Describe the mental status examination, with pertinent findings, and discuss the results of any psychological or personality testing performed.**

   Please see Mental Status Examination. The claimant presents with impairment in orientation, memory, and intellectual functioning. She appears confused. No specific psychiatric testing was done, given that this is a psychiatric evaluation.

5. **List all current diagnoses according to the DSM and provide a well-rationalized explanation to confirm or negate a causal relationship between any condition(s) found and the accepted work injury or employment factors (as described in the Statement of Accepted Facts). Also, please provide your reasoned medical opinion as to whether the work injury or employment factors caused, aggravated, accelerated, or precipitated the diagnosed condition(s).**

Current diagnosis of major neurocognitive disorder, probably due to Alzheimer's disease. This is not causally related to the work-related injury or work-related employment factors. She may have had a previous major depressive disorder that is not present at this time and/or is adequately treated with her current medicine and in remission.

6. **If the work injury aggravated an underlying/pre-existing condition, is such aggravation temporary or permanent? If temporary, has the condition now returned to the pre-injury status and has the aggravation ceased? If permanent, please explain how the work-related aggravation has affected the concurrent condition permanently (rather than temporarily)?**

   It does not appear that the work-related injury aggravated an underlying or pre-existing condition because no pre-existing psychiatric condition was established. However, in her present state, she cannot work given that she needs total assistance with activities of daily living due to her major neurocognitive disorder.

7. **Has the work-related condition(s) resolved? If not, is there evidence to support that the above work-related condition(s) is still active and causing objective findings? Provide a clear, rationalized explanation as to how you arrived at your opinion, including the specific findings from your examination/evaluation. If the work-related condition(s) has not resolved, please explain when recovery should be expected.**

   There is no apparent depression or anxiety at this time, and therefore no work-related condition. However, she is not able to work due to her major neurocognitive disorder diagnosis. Her condition is permanent.

8. **Based on clinical presentation of the work-related condition, is xxx currently capable of returning to her date of injury job as a xxx, as outlined in the Statement of Accepted Facts? Please explain the basis for your opinion.**

   No, she is not capable of returning to her job as a xxx secondary to her diagnosis as previously mentioned. Again, her current diagnosis is unrelated to her work injury or employment factors.

9. **If xxx is unable to return to her date of injury job due to the work-related condition, are work restrictions/limitations medically warranted? Please explain the basis for your opinion with specific detail as to how she can or cannot function in daily activities. Discuss any limitations in her ability to give or take supervision, cooperate with others, work under deadlines, or any pertinent factors which may affect work capacity. Please assess separately the contribution of her non-industrial Alzheimer's condition. Please complete the attached OWCP-5a outlining this individual's work capabilities.**

She is retired and is not cognitively intact enough to return to work if she could or had an interest. I have completed Form OWCP-5a.

10. **Discuss the prognosis and whether there is a need for any further treatment for the work-related condition. Please provide the basis for your opinion and outline any treatment recommendations.**

    The prognosis is guarded given her major neurocognitive disorder diagnosis. She is cooperative and would benefit from continued treatment with her antidepressants and the Aricept to slow the degenerative process. Again, this condition is not work-related, but she does require treatment.

Respectfully yours,

[redacted]

Jesse Carr, M.D.
Diplomat in Psychiatry of the American Board of Psychiatry and Neurology
[redacted]

Consultative Examination Services, Inc.

JESSE CARR, M.D.
Diplomat in Psychiatry of the American Board of Psychiatry and Neurology

2810 E del Mar Boulevard, Suite 4
Pasadena, CA 91107

[redacted]

[redacted]

RE: xxx
CalPERS ID#: xxx
Employer: xxx
Occupation: xxx

INDEPENDENT MEDICAL EVALUATION

To Whom It May Concern:

Pursuant to the request of your department, a **COMPLETE PSYCHIATRIC EVALUATION** was performed at this medical facility. The findings noted below are an assessment of a mental impairment affecting the above-captioned individual's functioning, not an assessment to be used for treatment purposes. Disclosure of the information in this report to the above-captioned individual may be medically detrimental to the individual's mental health.

IDENTIFICATION:

The claimant is a xx-year-old female who presented for this appointment on time. The claimant was able to provide picture ID upon checking in for this appointment. The claimant lives with her son. She appears adequately groomed. She looked her stated age.

SOURCE OF INFORMATION:

The source of information for this evaluation was the claimant who was an adequate historian and spoke English fluently. Medical records were also reviewed.

CHIEF COMPLAINT:

Depression.

REVIEW OF RECORDS:

There were several records, 57 pages in their entirety, as I reviewed them it appears that her last day on the job was [redacted]. Retirement date was [redacted]. Disability occurred [redacted]. She had a slip and fall with a decline in health and unable to return to work.

I reviewed several notes by Dr. [redacted] on dates of [redacted] and the notes appear to be similar. They report a number of physical impairments and injuries where she is unable to stand, sit or walk and chronic pain, but from a psychiatric point of view, there are reports of Major Depressive Disorder symptoms. Also, there was a diagnosis of Dysthymia. There are also reports of depression symptoms including decreased concentration, decreased short-term memory, and trouble with communication.

Subsequent notes, there was talk about depression, loss of interest in usual activities, anhedonia, patient being very depressed. The claimant was apparently started on Trintellix 10 mg in [redacted] according to the records as well as Xanax 0.5 mg as needed. There is some report that the son was against additional medicines. It appears on [redacted] the patient was started on Lexapro 10 mg per day and trazodone 50 mg at bedtime. On a note dated [redacted] by Dr. [redacted] reported the claimant with lots of psychiatric complaints of loneliness, decreased sleep, tiredness, low energy, trouble getting started. Diagnosis of Mild-to-Moderate Depression and Anxiety, and Major Depressive Disorder and Dysthymic Disorder.

Record on [redacted] reported depression and was diagnosed with Major Depressive Disorder.

[redacted], the same findings by the same doctor.

Note on [redacted], the same diagnoses of Major Depressive Disorder Mild-to-Moderate.

Department of Motor Vehicles Position Duty Statement was reviewed. Classification title is Motor Vehicle Representative. Under the direction of the manager, the incumbent performs tasks in an environment which routinely requires a calm, courteous, and tactful approach in providing customer service. Interacts respectfully and effectively with supervisors, peers, other departmental employees and supporting agencies contributing to the overall efficiency and productivity of the office. Essential/marginal functions were also reviewed.

HISTORY OF PRESENT ILLNESS:

Ms. Xxx is a xx-year-old female with complaints of depression. She had a slip and fall with a decline in health and has been unable to return to work. Her energy level is low. That makes it difficult for her to function significantly. Interests in things have diminished. She reports experiencing no joy, reports having decreased concentration, often is forgetful when she goes to the refrigerator; she will forget what she went there for. Motivation is low. She spends lots of time worrying, anxious, and upset about the past. She has been isolating and avoiding people. She doesn't even like talking with family members, stating that she feels like a vegetable. She feels like there is no way that she could return to work in her current state because she just cannot stand to even see people. She cannot maintain eye contact and her concentration is quite impaired according to her report. The claimant does appear very distractible. At times she gets overwhelmed and it makes it difficult for her to fully participate with the examination process. She was anxious, dysphoric, withdrawn, had difficulty understanding even simple questions. The claimant denies any suicidal or homicidal ideation at this time. She denies any auditory or visual hallucinations. No delusions elicited. The claimant does complain of hearing her name being called, but no other unusual perceptual disturbances.

EMPLOYMENT HISTORY:

According to the claimant, she was born in [redacted]. She came to the U.S. in the year [redacted]. When she was in [redacted] she worked office jobs for about 18 years. She reports when she came to the U.S. she did some student work at a college, [redacted] College. She did that for five years and then she started working at the [redacted] about 12 years ago. She worked for the [redacted] for 10 years and then has been out on disability for the last 2 years.

FAMILY, SOCIAL, AND ENVIRONMENTAL HISTORY:

As previously stated, the claimant was born in [redacted] She is currently living with her son. She has been separated for two years. She has [redacted].

EDUCATIONAL HISTORY:

She is a high school graduate and has an AA Degree in computers.

HABITS:

The claimant denies any alcohol or drug use.

MILITARY HISTORY:

Denied.

LEGAL HISTORY:

Denied.

PAST MEDICAL HISTORY:

Medical history is significant for a history of low back pain that started in [redacted] history of arthritis in her back, legs, and knees. She reports a history of hypertension. She did report that she sustained a fall five years ago with a left foot fracture and some dislocations and at that time she was off work for two weeks. The claimant denies any allergies to any medication.

PAST PSYCHIATRIC HISTORY:

PSYCHIATRIC HOSPITALIZATIONS: Denied previous psychiatric hospitalizations.

OUTPATIENT PSYCHIATRIC TREATMENT: Her first psychiatric treatment was by Dr. [redacted] She has been seeing him for a year and he has been treating her with Lexapro 20 and Xanax 0.5 mg per day with not much benefit in terms of treating her depression. She denies current suicidal ideation. She denies previous suicide attempts, denies auditory or visual hallucinations, no paranoia, no history of mania, no history of Obsessive Compulsive Disorder, no history of PTSD, and no history of an eating disorder.

FAMILY PSYCHIATRIC HISTORY:

The claimant reports that her brother did commit suicide a few years back, but she has a mother and two sisters with a history of depression. She reports that her father was an alcoholic and was abusive toward her mother during her childhood. She reports that she was raised by both parents, but not very happy as a child. She is the third of six siblings. She reports that she did okay in school and was married one time.

MARITAL HISTORY:

She has been married once. She has been separated for two years.

CURRENT MEDICATION:

She takes Meclizine, meloxicam, Lexapro 20 mg per day, tramadol, Xanax 0.5 mg per day, lisinopril, and trazodone 50 mg at bedtime.

ACTIVITIES OF DAILY LIVING:

As previously described, she says she wakes up, takes a shower with assistance, eats, naps throughout the day, has trouble reading, does not watch TV because she just thinks about things too much and worries too much. She is not driving because of her physical injuries, but also reports that she feels like a vegetable and has a hard time focusing.

MENTAL STATUS EXAMINATION:

APPEARANCE, ATTITUDE, AND BEHAVIOR: The claimant appears adequately groomed. She is wearing some type of brace on her right hand and wrist. She appears somewhat overweight. She was casually dressed. Her behavior is somewhat guarded. She looks in distress. Eye contact is poor. Her psychomotor activity appears to be slowed.

THOUGHT PROCESS: As previously stated were slow, hesitant, guarded. Her thoughts were circumstantial.

MOOD AND AFFECT: The claimant complains of feeling depressed. She looks depressed and her affect is blunted. There does appear to be some psychomotor retardation.

SPEECH: Speech is slow and monotone and soft.

INTELLECTUAL FUNCTIONING: The claimant was oriented to person, place, situation, day and month.

MEMORY: The claimant was able to recall three words immediately, but only two out of three words five minutes later. Remote memory was poor. The claimant recalls some details of the past, but had difficulty with specific dates and time.

CONCENTRATION AND CALCULATION: Concentration was poor. The claimant was not able to spell the word “world” forward or backwards. Intellect appeared to be somewhat below average. She scored 19/30 on the Mini Mental Status Examination.

INSIGHT AND JUDGMENT: Insight was fair to poor. Judgment was poor.

PROVERB: The claimant had trouble with proverbs, often thinking in concrete terms.

SIMILARITIES AND DIFFERENCES: The claimant had difficulty with simple comparisons like the comparisons of “What does a table and a chair have in common?” She stated that she did not know. She had difficulty focusing on questions.

FUND OF KNOWLEDGE: The claimant's fund of knowledge was poor. When asked who the current President of the United States was, she said, "Donald Trump," not recognizing that there was a recent election. When asked who the President was prior to Donald Trump, she said, "Bush."

Mini Mental Status Examination

It was administered and the claimant scored a 19/30 which is in the low range, which suggests some significant cognitive impairment. The areas that she had difficulty with: She had problems with attention and calculation. She could not do serial 7s. When asked to take away 7 from 100, she said she did not know. Then I asked her to subtract 3 from 20, she gave the answer of 9 and then could not subtract 3 from 9. She had some difficulty in following through and paying attention. Her recall was impaired, she was only able to recall 2/3 objects after five minutes. She was slow through most parts of the examination. She had difficulty copying a common object. She was very slow in the reading section and so her final score was a 19/30 which is suggestive of Moderate Cognitive Impairment.

DIAGNOSES DSM-V:

Major Depressive Disorder, Severe, Single Episode.
Current Functioning/GAF of approximately 30/100.

PROGNOSIS:

From a psychiatric standpoint, the prognosis is guarded. She does not appear to have made progress despite an apparent trial on two different antidepressants. She still remains as severely depressed as she was at the beginning.

SPECIFIC QUESTIONS:

1. **Does the member have an actual and present psychiatric (depression) impairment that arises to the level of substantial incapacity to perform her usual duties?**

   Yes, the claimant does have significant impairment that arises to the level of substantial incapacity to perform her usual duties due to her Major Depressive Disorder.

2. **Considering the member's subjective complaints and the objective findings (or lack thereof) on exam, what findings lead you to the conclusion the member is or is not substantially incapacitated? Please explain fully.**

   The claimant is substantially incapacitated. When we look at her essential functions in terms of driver's license registration, the claimant would have difficulty dealing with the

public. Her concentration is so impaired as manifested during the examination that she would have difficulty registering or titling vehicles, following through with instructions, being able to give people instructions or to be able to explain forms, or being able to verify people's identity. She would have great difficulty based on her level of depression, her trouble with concentration, some of her cognitive impairment and her restriction in her ADLs. In terms of her job duties of cashiering and inventory, that would also be difficult given that she would have difficulty with counting and doing simple arithmetic. Her memory is significantly impaired, so this would be significantly impaired customer service. The claimant has been isolating, is fearful of going out, does not talk to people, does not make eye contact, so this would be significantly impaired and significantly incapacitating. In terms of eligibility verification, the claimant would not be able to do this function as well for the previous mentioned reasons. Training would be difficult for her to follow any educational or informal training methods. Again, secondary to the severity of her depression, crying spells, feeling overwhelmed, significant anxiety, all of these would impair her ability to follow through consistently with any type of training.

3. **If you find the member to be substantially incapacitated, is the incapacity permanent or temporary? (As specified in California Public Employee Retirement Law G.C. 20026) If temporary, will the incapacity last longer than 12 months? Please explain in detail.**

   Her incapacity appears to be greater than six months, so under that definition it is likely to be permanent given that she has made very limited progress in the two years of treatment.

4. **Please list the specific Job Duties and/or Physical Requirements of Position the member is unable to perform <u>for each</u> substantially incapacitated body part/condition.**

   Please see answer to question #2.

5. **As of what date did the member's condition become "substantially incapacitating"? What objective medical evidence leads you to your conclusion the member is substantially incapacitated based on the date you are providing?**

   It appears that she has been substantially incapacitated for the last two years. It appears that [redacted] is the date when she was substantially incapacitated. It seems that her condition with her depression substantially increased and has not diminished despite treatment since that time.

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

It appears the claimant is making a decent effort, but does get easily frustrated. I did find that her not being able to subtract 3 from 20 was a bit of an exaggeration, but clearly she has impairment with her depression, concentration, focus, and memory that substantially interferes with her functioning.

PSYCHIATRIC REHABILITATION:

It would be recommended the claimant continues to get psychiatric treatment from her psychiatrist. It is possible the claimant could make some improvement, but given the fact that she has not made any substantial improvement to two different trials on antidepressants would suggest that her condition is likely to be permanent.

Respectfully yours,

[redacted]

Jesse Carr, M.D.
Diplomat in Psychiatry of the American Board of Psychiatry and Neurology
[redacted]

December 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: January 4, 2023, Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
DIVAKAR KRISHNAREDDY, M.D. – ORTHOPEDIC SURGERY

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Divakar Krishnareddy M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

Divakar Krishnareddy, M.D., is Board Certified in Orthopedic Surgery. He received his medical degree from the Andhra University in 1970 and completed residencies at the University Hospital of West Indies, Misericordia Fordham Hospital and Albert Einstein College of Medicine and a fellowship with Rancho Los Amigos Hospital. Dr. Krishnareddy has 20+ years of experience as an independent medical examiner performing medical legal evaluations for both public and private organizations.

Upon approval to the panel, LACERA will conduct a virtual orientation with DRS staff, legal counsel and the physician and his management team to provide a comprehensive overview of the LACERA Panel Physician Guidelines, requirements, and protocols to ensure a thorough understanding of the Rules in Evaluating Applicants, Disability Retirement Law Standards, and what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff will also cover report submission timeframes, fee schedule and billing procedures. Additional diagnostic testing request protocols; medical license, Board Certification, and insurance coverage requirements. Lastly, staff will provide an overview of the Quality Control Questionnaire process and procedures.

On December 21, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Divakar Krishnareddy, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application Divakar Krishnareddy, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

/TLC

LACERA
Los Angeles County Employees Retirement Association
300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-6132 • 800/786-6464

APPLICATION TO LACERA PANEL OF EXAMINATION PHYSICIANS

ALL APPLICANTS MUST SUBMIT THE FOLLOWING WITH THEIR APPLICATION

- ✓ Current Curriculum Vitae
- ✓ Two (2) Sample" Medical Reports – Must be Redacted
- ✓ Copy of Medical License
- ✓ Copy of Board Certification(s) – Applicant must be board certified to qualify for panel
- ✓ Certificate of Insurance

GENERAL INFORMATION Please attach a list of any additional locations.	Date 9-1-22
Physician Name: Divakar Krishnareddy MD	Group Name:
Primary Address: Mailing Address - IME's 4849 Van Nuys Blvd #202, Sherman Oaks CA 91403	
Primary Contact: Elainna Moss	Title: Administrator Med Health Services
Telephone: (818) 990-4497	Email: info@medhealthLA.com.
Secondary Address: 1) 16444 Paramount Blvd #204, Paramount 90723 2) 630 W. Duarte Road, #203, Arcadia CA 91007	
Telephone: (818) 990-4497	Email: info@medhealthLA.com

See Attached IME List

PHYSICIAN BACKGROUND	
Field of Specialty: Orthopaedic Surgery Board Certification ☒ Yes ☐ No	Subspecialty: Spinal Fellowship Board Certification ☐ Yes ☐ No
License # A356665 Expiration Date: 4/30/24	
Has your license been suspended in the last 3 years? ☐ Yes ☒ No	
Has there been any disciplinary actions filed against you in the last 3 year? ☐ Yes ☒ No	

EXPERIENCE AND CURRENT PRACTICE
Indicate the number of years of experience that you have in each category and the time spent performing each activity.

Type	Number of Years	Current Practice	Time Spent (%)
AME		Treatment	20%-25%.
IME	20+	Evaluations	75%.
QME	10+	Research	
Workers' Compensation Evaluations	30+	Teaching	5%-10%.
Disability Evaluations	same as IME.		100 %
Med-Legal Reports	20+		

DC

QME/IME -ADDRESS:

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

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

MAILING ADDRESS:
4849 Van Nuys Blvd, Suite 202
Sherman Oaks, CA 91403
Appointments: (818) 990-4497
Fax (818) 990-6045

Performing Medical Evaluations for Public Organizations	[X] Yes [ ] No
Performing Medical Evaluations for Private Organizations	[X] Yes [ ] No
Please Names of Organizations:	Multiple - City of LA. City of Long Beach Whole Foods. AIG LAUSD HealthPartner

Estimated Time from Appointment to Examination: [X] 2 weeks [X] 3-4 Weeks [ ] Over a month	Able to Submit a Final Report and Invoice in 30 days: [X] Yes [ ] No

LACERA FEE SCHEDULE	
Physical Exam and Initial Report	$2,015.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Record Review Only and Initial Report	$1,007.50 + Additional Fee for Reviewed Records* (see Review of Record rate)
Psychiatric/Psychological Examination (in office) and Initial Report*	$ 4, 030.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Psychiatric/Psychological Examination (no exam) and Initial Report*	$ 2,015.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Toxicology and Oncology Examination (in office) and Initial Report*	$ 3,022.50 + Additional Fee for Reviewed Records* (see Review of Record rate)
Toxicology and Oncology Examination (no exam) and Initial Report*	$ 1,511.25 + Additional Fee for Reviewed Records* (see Review of Record rate)
*Review of Records (by Physician)	$ 455.00 per inch (LACERA will pay up to 1 hour of record-review per inch of medical records)
*Review of Records (by Nurse)	$ 75.00 per inch (LACERA will pay up to 1 hour of record-review per inch of medical records)
Supplemental Report	$ 455.00 per hour
Supplemental Report when Panel Physician Guidelines were not followed	No charge

Other Fees	
Administrative Hearing Preparation	$ 455.00 per hour
Depositions	$ 455.00 per hour with 2 hours minimum
Expert Witness in Superior or Appellate Court	$3,500 – Half Day
Expert Witness in Superior or Appellate Court	$7,000 – Full Day

Cancellation Policy and Fees
Please indicate your cancellation policy and any applicable fees.

What is you Cancellation Policy? (Attach policy, if applicable).
$500 if the cancel is less than 7 days.

Cancelled Exams that do not adhere to your stated policy:	Fee: $
Cancelled Hearings that do not adhere to your stated policy:	Fee: $

N/C

Name of person completing this form:

Print Name: Diwakar Krishnareddy	Title: MD.
Physician Signature:	Date 8/31/22

You may attach additional pages if necessary.

Revised: 12/8/21

Curriculum Vitae

DIVAKAR R. KRISHNAREDDY, M.D.

Diplomate, American Board of Orthopedic Surgery

Orthopedic Surgeon & Spine Surgeon

QME/IME -ADDRESS: 16444 Paramount Blvd, Suite 204
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EDUCATION:

Andhra University
Visakhpatnam, India
Pre Medical & Biological Science (1962-1964)

Andhra University
Visakhpatnam, India
Doctrine of Medicine (1964- 04/1970)

INTERNSHIP:

King George Hospital
Visakhpatnam, India
Rotating Internship (07/1971-06/1972)

RESIDENCY:

University Hospital of West Indies
Mona, Jamaica W.I.
Orthopedic Surgery (07/1972-06/1975)

Misericordia Fordham Hospital
Bronx, New York
General Surgery (07/1975-06/1976)

Albert Einstein College of Medicine
Bronx, New York
Orthopedic Surgery (07/1976-06/1980)

FELLOWSHIP:

Rancho Los Amigos Hospital
Downey, California
Fellowship in Spine (1980-1981)

CERTIFICATIONS:

Educational Commission for Foreign Medical Graduates
Certificate Number 148-382-5 (01/1974)

American Board of Orthopedic Surgery
Orthopedic Surgery (07/1985)

QME – State of California

PROFESSIONAL SOCIETIES:

North Carolina Medical Society
American Association of Orthopedic Surgeons
California Orthopedic Association
North Carolina Spine Surgeons Society
American Academy of Orthopedic Surgeons

ACADEMIC APPOINTMENTS:

University of Southern California
Irvine, California
Clinical Assistant Professor (1993-1998)

Pomona Osteopathic Medical
Pomona, California
Clinical Assistant Professor (1992-1998)

WORK HISTORY:

Healthpointe Medical Group, Inc.
Anaheim, California
Orthopedic & Spine Surgeon (05/2012-2022)

Med Health Services, Inc.
Sherman Oaks & Arcadia, California
QMEs/AMEs & IMEs
Orthopedic & Spine Surgeon (02/2017-Present)

Krishnareddy MD, Inc.
Culver City, California
Orthopedic & Spine Surgeon (03/2010-12/2012)

Serra Medical Clinic, Inc.
Sun Valley, California
Orthopedic & Spine Surgeon (07/2003-06/2009)

Vance Orthopedic Surgery
Henderson, North Carolina
Orthopedic & Spine Surgeon (09/1998-06/2003)

Center Orthopedic Surgery
Brea, California
Orthopedic & Spine Surgeon (06/1981-09/1998)

HOSPITAL AFFLIATIONS:

Coast Plaza Doctors Hospital
Norwalk, California
Provisional (09/2012)

Tri- City Regional Medical Center
Hawaiian Gardens, CA
Provisional (10/2012)

Pacifica of the Valley Hospital
Sun Valley, California
Active (2003)

Whittier Hospital Medical Center
Whittier, California
Provisional (08/2014)

Anaheim Regional Medical Center
Anaheim, California
Provisional (10/2014)

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(626) 447-8870

SAMPLE

[redacted]

[redacted]

[redacted]

RE: [redacted] VS. [redacted] INC.

CLAIMANT :
WCAB NO :
CLAIM NO :
EMPLOYER :
ACCT. NO :
D/INJURY :
D/EXAMIN :

[redacted]

ORTHOPEDIC PANEL QME EVALUATION

Dear [redacted]

Today, I had the opportunity to perform an Orthopedic Panel QME Evaluation in my [redacted] office on [redacted], a [redacted] year-old, right-handed male. He gives me the following history directly. Medical records are also supplied which I have had the opportunity to review.

EMPLOYMENT:

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

The patient worked as a carpenter for [redacted] & [redacted] for approximately many years prior to his onset of orthopedic symptoms. He is unclear of the exact date he began working for this employer, but states it was many years. He did various construction jobs through this employer. It appears he last worked for this employer a few years ago.

He is presently working for a different employer, [redacted] Inc, performing a commercial job as a safety worker. He does not do any significant lifting, pushing, pulling, or squatting activities. Essentially, he is doing somewhat limited duty work. He is not doing the type of work he was doing previously. He states he intermittently performed work for several other constructions companies during brief periods of lay off from [redacted] & [redacted], but denies any injures with those employers.

HISTORY OF PRESENT INJURY:

The patient states he first injured his right knee as a result of throwing wood into a trash dumpster when he twisted as he was throwing the trash inside. This was sometime around [redacted]. He states that around that same time he began to have pain in his shoulders due to the amount of lifting and overhead activities he had to do in constructions. As he continued to work he also developed the onset of left knee pains.

He was first seen for treatment in [redacted] with complaints of shoulder and knee pain and also some hearing problems. He states he treated at [redacted] on and off for pains in his knees and shoulders for a few years.

He received about 10 months of physical therapy and acupuncture, as well as took medications.

He later came under the care of Dr. [redacted] who then ordered MRIs of his knees and shoulders. He was also referred to an ENT for his hearing problems.

He states he continued to work, but his knees and shoulders go progressively worse. He then was referred to Dr. [redacted] He was told he studies were abnormal and may need surgery.

He was laid off from [redacted] and [redacted] and indicates after that he worked for a few other companies, but tried to do lighter work, so he could continue to work.

He is no longer under treatment and thinks it has been about 18 months since he last had treatment.

PRESENT COMPLAINTS:

Bilateral shoulder pain. He states he is able to do "everything" but has increased pain with any attempt at reaching or stretching his arms above his shoulders.

Bilateral knee pains. Again, he states he can do all activities, but has increase pain with cold weather, and he avoids kneeling and squatting.

PAST MEDICAL HISTORY:

WORK INJURIES:

None prior that he can recall. He reports only the hearing problems.

ILLNESSES:

Hypercholesterolemia.

MEDICATIONS:

None.

ALLERGIES:

None.

SURGERIES:

Heel spurs.

AUTOMOBILE ACCIDENTS:

Denied with any injures.

SOCIAL HISTORY:

The patient does not smoke cigarettes. He drinks three beers daily.

FAMILY HISTORY:

Noncontributory.

REVIEW OF MEDICAL RECORDS:

[redacted]

[redacted]. Faxed copy of Cover letter noting I am to see the patient on [redacted] for a Panel QME. Notes he was employed as carpenter and is claim CT to the knees, shoulders and hearing loss. Claim was denied.

[redacted] &

[redacted]: [redacted] M. [redacted] Cover letter noting I am to see the applicant on [redacted] This is a cumulative trauma injury while working as a carpenter from [redacted] with claims for bilateral shoulder, bilateral knees and industrial basis ears/hearing loss.

[redacted]

[redacted] State of California, Division of Workers Compensation/Workers Compensation Appeals Board Application for Adjudication of Claim. Claimed is cumulative trauma injury from [redacted] with injuries to ear, shoulders and knee (patella) from exposure to loud construction noise, repetitive pulling, heavy lifting, carrying, kneeling, climbing hammering.

[redacted]

[redacted]: Comprehensive Industrial Medical-Legal Otolaryngologic Evaluation. Hearing loss evaluation. Ratable hearing loss of 25%.

[redacted] M.D.:

[redacted] Doctor's First Report of Occupational Injury or Illness. Seen for injury of [redacted] which patient indicated at occurred at work when he fell against the blunt

end of a pole. Pain rated as 3/10. Chest x-ray was negative. Diagnoses: Contusion of chest wall, right ribs. Prescription for naproxen 220 mg, rib belt, dispensed hot/cold pack.

[redacted] Chief complaint of slipping on "brace rob" with resultant injuring of ribs, now with rib pain. Diagnosis: Contusion of chest wall, right ribs, resolved. Plan: Released from care. Impairment rating: 0%.

[redacted]

[redacted], Safety Representative. Employer's Report of Occupational Injury or Illness. Employee was carrying wood when prybar slipped and he hit metal turn-buckle, injuring ribs.

[redacted] D.:

[redacted] and [redacted]: Radiology/Diagnostics. Audiometry on [redacted] hearing loss.

K[redacted]

20[redacted]

[redacted], M.D. Health Maintenance Exam. Complaining of foot pain. History of heel pain with pain on active exercise. Also history of finger injury with limited range of motion noted of left index finger. Noted hand laceration. Diagnoses: 1) Heel pain. 2) Dizziness. Heel cup ordered. Labs ordered.

20[redacted]

[redacted] Patient complains of knee pain when jogging as well as chest discomfort when working or pushing. Also complains of bilateral shoulder pain, scalp problem and hearing problem. He has refused therapy. Diagnoses: 1) Chest pain. 2) Hyperlipidemia. 3) Seborrheic dermatitis. 4) Shoulder joint pain. 5) Tinnitus. Labs taken showing abnormal EKG and elevated TSH.

[redacted] Plan: Labs.

[redacted] P.A. Office visit: Patient is a [redacted]ear old male who

sustained a left knee injury three days before. Mechanism of injury: Fall. Also complains of right heel pain as well as dizziness. He had heel spur surgery before. Diagnoses: 1) Dizziness. 2) Heel pain. Diagnoses: 1) Osteoarthritis of knee. 2) Strain of knee. Plan: X-ray of left knee. Labs.

[redacted] M.D. X-ray of left knee. Impression: No significant abnormality.

[redacted] Office visit: Patient complains of right foot pain and right knee pain. He already changed shoes, but it is still painful. Because of such, he has been off balance and feels that knee also has an ache. Requesting for cream for his feet and erectile dysfunction.

Also notes on hearing tests, treadmill, audiometry, angina, erectile dysfunction, prediabetes, onychomycosis, essential hypertension.

20[redacted]:

[redacted] M.D. Patient presents for annual visit. Complains of right foot pain, right shoulder pain greater than 3 months, right knee pain more than 3 months. Patient noted to be noncompliant with meds. Diagnoses: 1) Hyperlipidemia. 2) Chronic right foot pain. 3) Right shoulder joint pain for more than 3 months. 4) Right knee joint pain for greater than 3 months.

[redacted] M.D. X-ray of right knee. Impression: 1) Exostosis from the right proximal fibula. 2) Mild degenerative changes.

[redacted]. X-ray of right shoulder. Impression: 1) Moderate degenerative changes at the AC joint.

[redacted] X-ray of right foot. Impression: Within normal limits however calcaneal spurs noted.

[redacted] M.D. Complaining of right knee pain at 8/10, started day before right after work. Just started working construction after having been off a few weeks. Asking for disability. Told that if he wants full disability, needs to get disability lawyer. Diagnosis: Right knee pain. Plan: 1) Use ibuprofen for pain. 2) Refer to physical therapy for knee. 3) Advised to find disability lawyer for permanent disability.

4) Return if symptoms worsen.

[redacted], P.T. Physical Therapy Evaluation for right knee.

Also noted are diagnoses for hyperlipidemia and prediabetes.

[redacted] Medical Center:

[redacted] M.D. Initial Comprehensive Primary Treating Physician's Report. Patient is a [redacted] year-old male, who has been working as a Carpenter for [redacted], Inc for [redacted] years. His usual and customary duties consisted of building frames, organizing and handling equipment. The physical demands of his job consisted of performing repetitive pulling, lifting, carrying, kneeling, climbing and using heavy equipment in a frequency of 7-10 hours per day. He was also exposed to noise. The patient stated that during the period from [redacted] he sustained cumulative type of injuries, as a result of which, he developed pain in his ears, shoulders and knees. He noted gradual onset of pain in his ears, shoulders and knees. He never reported the injuries since he was afraid of losing his job. He sought medical care on his own at [redacted] where he was evaluated, underwent x-rays and was prescribed pain medications. Present complaints: 1) Hearing loss. 2) Burning bilateral shoulder pain radiating down the arms to the fingers, associated with muscle spasms. The pain is aggravated by gripping, grasping, reaching, pulling, lifting, and doing work at or above the shoulder level. 3) Bilateral knee pain and muscle spasms. The pain is aggravated with squatting, kneeling, ascending or descending stairs, prolonged positioning including weight bearing, standing, and walking as well as numbness, tingling, and pain radiating to the feet. Pain is alleviated with medications, rest and activity restriction. Diagnoses: 1) Hearing loss. 2) Bilateral shoulder sprain/strain rule out internal derangement. 3) Bilateral knee sprain/strain rule out internal derangement. Plan: Medication prescriptions given: Fanatrex, cyclobenzaprine, synapryn, ketoprofen cream, deprizine, tabradol, dicopanol. 2) Authorization for x-rays and MRIs. 3)TENS unit with supplies for home use. 4) Physiotherapy and shockwave therapy. 5) Functional capacity evaluation. 6) ENT referral. 7) EMG/NVC testing. Work status: TTD from [redacted], although Dr. [redacted] noted that he did this without having a job description. Should he have one and the patient be able to work, he would place patient on modified duties.

[redacted]: Dr. [redacted] PR-2: No change in symptoms, diagnoses or plan.

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

[redacted] Dr. [redacted] PR-2: Patient complains of hearing loss, bilateral shoulder pain radiating down the arms to the fingers associated with muscle spasms and bilateral knee pain and spasm. He also complains of numbness, tingling and pain radiating to the feet. The patient states that the symptoms persist, but the medications do offer him temporary relief of pain and improve his ability to have restful sleep.Diagnoses: 1) Hearing loss. 2) Bilateral shoulder sprain/strain rule out internal derangement. 3) Bilateral knee sprain/strain rule out internal derangement. Plan: Continue meds. Referral to orthopedic surgeon for bilateral shoulders and knees. PRP treatment for bilateral shoulders and knees. Work Status: TTD.

[redacted]: Dr. [redacted] PR-2. No change in symptomatology, diagnoses or plan.

[redacted] Dr. [redacted] PR-2 Report. No change in symptoms or diagnoses. Referred to ENT. PRP treatment. Follow-up in four weeks. Work Status: TTD

[redacted] PR-2. Diagnoses: 1) Bilateral shoulder internal derangement. 2) Bilateral knee internal derangement. Plan: Continue medications. Work Status: TTD.

[redacted]: Dr. [redacted] No change in symptomatology or diagnoses. Referral for ENT and orthopedic evaluations. Referred for EMG/NV of bilateral upper and lower extremities. Physical therapy, acupuncture and chiropractic treatment 3 x 6 weeks. Continued medications. Work Status: TTD

[redacted], M.D. Ortho. PR-2 Report. No change in symptoms or diagnoses. Plan: MRIs of the bilateral shoulders and knees. Physical therapy, acupuncture and chiropractic treatment 3 x 6 weeks. Continue medications.

[redacted] M.D. Ortho. PR-2 Report. Cumulative trauma injury of [redacted] No change in symptoms or diagnoses. Plan including request for physical therapy, chiropractic treatment and acupuncture 3 x 6 weeks and now shockwave therapy as well as orthopedic referral. Work Status: TTD.

[redacted] Dr. [redacted] PR-2. Diagnoses: 1) Hearing loss. 2) Sprain of left rotator cuff capsule. 3) Unspecified derangement of shoulder, right. 4) Tear, medial meniscus, bilateral knee. 5) Tear, lateral meniscus, bilateral knee. Dr. [redacted] continued with Dr. [redacted] plans.

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

[redacted] Dr. [redacted] No change in symptoms, diagnoses or plans.

[redacted] Dr. [redacted] Complaints of bilateral knee pain at 7/10 and bilateral shoulder pain at 7/10. Diagnoses: 1) Hearing loss. 2) Sprain of left rotator cuff capsule. 3) Unspecified derangement of shoulder, right. 4) Tear, medial meniscus, bilateral knee. 5) Tear, lateral meniscus, bilateral knee. Plan: Continue medications.

[redacted]maging Medical Grou[redacted]

[redacted] M.D. MRI of the Right Shoulder: Impression: 1) Laterally downsloping, flat acromion. 2) Osteoarthritis of acromioclavicular joint. 3) Partial-thickness tear of the supraspinatus. 4) Partial-thickness tear of the infraspinatus. 5) Synovial effusion. 6) Subacromial/subdeltoid bursitis. 7) Subcortical cysts in the humeral head. 8)SLAP type II lesion of the glenoid. 9) Partial thickness tear of the biceps tendon. 10) Partial thickness tear of the subscapularis

[redacted] Dr. [redacted] MRI of the Left Shoulder. Impression: 1) Laterally downsloping, flat acromion. 2) Osteoarthritis of acromioclavicular joint. 3) Partial-thickness tear of the supraspinatus. 4) Partial-thickness tear of the infraspinatus. 5) Synovial effusion. 6) Subacromial subdeltoid bursitis. 7) Subcortical cysts in the humeral head. 8) SLAP type II lesion of the glenoid. 9) Partial-thickness tear of the biceps tendon. 10) Partial-thickness tear of the subscapularis.

[redacted] Dr. [redacted] MRI of the Right Knee. Impression: 1) Horizontal tear involving the posterior horn of the medial meniscus. 2) Complex tear involving the anterior horn of the lateral meniscus. 3) Linear increased signal in the posterior horn of the lateral meniscus, likely reflects internal degeneration but a tear of the posterior horn is not excluded. 4) Lateral collateral ligament complex sprain versus partial-thickness tear. 5) Patellar chondromalacia. 6) Knee joint effusion

[redacted], M.D. MRI of the Left Knee. Impression: 1) Medial meniscus tear, posterior horn and body segments; the body of the meniscus is partially extruded out of the joint space. 2) Lateral meniscus tear, anterior horn; type II myxoid (composed of clear, mucoid substance, i.e., resembling mucus) change, posterior horn partially discoid lateral meniscus. 3) Semimembranosus tendinosis. 4) Partial tear of posterior cruciate ligament. 5) Patella chondromalacia, grade 3. 6) Medial femorotibial joint space narrowing and osteoarthritis.

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

[redacted], [redacted] M.D. Radiology. Right Shoulder MRI. Impression: Supraspinatus partial tendon tear. Infraspinatus partial tendon tear, with associated 19 mm proximal peritendinous cyst. Subscapularis partial tendon tear. Moderate to marked teres minor muscle atrophy. Biceps partial tendon tear, horizontal and vertical segments, tenosynovitis. Superior glenoid labral tear, SLAP type II configuration. Subdeltoid bursitis. Acromioclavicular joint and glenohumeral joint arthrosis. Subcortical cyst in the humeral head.

[redacted] Dr. [redacted] Left Shoulder MRI. Impression: 1) Supraspinatus and infraspinatus tendon tears. 2) Subscapularis tendinosis. 3) Teres minor muscle atrophy. 4) Superior glenoid labral tear, SLAP type II configuration. 5) Biceps tendon tears, horizontal and vertical segments. 6) Biceps tenosynovitis. 7) Subdeltoid bursitis. 8) Acromioclavicular joint and glenohumeral joint arthrosis.

[redacted] Dr. [redacted] MRI of Right Knee. Impression: 1) Complex tears, posterior horn and body segment of the medial meniscus. 2) Displaced tear involving the anterior horn of the lateral meniscus, with centrally displaced fragment adjacent to the lateral tibial spine. 3) Complex tear, body segment; cleavage tear, posterior horn. 4) Semimembranosus tendinosis. 5) Pes anserine bursitis. 6) Popliteus tendinosis. 7) Medial and lateral femorotibial joint arthrosis. 8) Patellar chondromalacia, grade 2/3.

[redacted].:

[redacted] X-ray of Right Shoulder. Impression: Calcification projecting over the lateral humeral head which may reflect calcific tendinosis.

[redacted] X-ray of Right Knee. Impression: 1) Sclerosis, medial tibial articular surface with associated medial compartment joint space narrowing. 2) Osteophytes of posterior aspect of patellar upper and lower poles. 3) Exophytic bony mass arising from the metaphyseal region of the proximal fibula in its posteromedial aspect.

[redacted] X-ray of Left Knee. Impression: 1) Sclerosis of the medial tibial articular surface, with associated medial compartment joint space narrowing. 2) Osteophytes off the posterior aspect of the patellar upper and lower poles. 3) Enthesophyte off the upper patellar pole anteriorly.

[redacted] M.D.:

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

[redacted] Discovery reports including evaluation of acromioclavicular and knee joints.

[redacted]: Anatomical Impairment Measurements (AiM) Report.

[redacted] M.D.:

[redacted] Initial Comprehensive Primary Treating Physician Report. The patient's work history was noted. He appears to have been referred to Dr. [redacted] Dr. [redacted]. He complained of bilateral shoulder and knee pain. Diagnoses: 1) Hearing loss. 2) Sprain of left rotator cuff capsule. 3) Unspecified derangement of shoulder, right. 4) Tear, medial meniscus, bilateral knee. 5) Tear, lateral meniscus, bilateral knee. Plan: Continue medications. Plan: Continue medications prescribed by Dr [redacted] Referral for orthopedic surgeon consult for left shoulder and bilateral knees. Referral to ENT specialist. Patient to have physical therapy, acupuncture and chiropractic treatment. Work Status: TTD.

[redacted], M.D.

[redacted] Qualified Medical Evaluation Report. Dr. [redacted] reviewed the patient's history. Past history of bone spur and hearing loss. Dr. [redacted] said patient had undergone physical therapy and acupuncture for bilateral knee and shoulder which had not been helpful. In his activities of daily living he denied all problems with ADLs except for sleep. This included no problems with standing, walking, stair climbing and reaching overhead. Patient was observed to walk with an antalgic gait to the right. Dr. [redacted] noted the patient to be vague and ambiguous during the examination. He wondered how truthful the patient was being. Diagnoses: Dr. [redacted] was noted not to give diagnoses, but instead referred the reader to the MRI results. Discussion: Dr. [redacted] indicated that the patient reported drinking one to two beers a day. His cumulative trauma injury was from [redacted] but there were no reports on the shoulders or knees until [redacted]. Therefore, cumulative trauma for the knees and shoulders should be on this date and not earlier. Findings were consistent with partial thickness tear, bilateral shoulders, rotator cuff tendons and biceps tendon with acromioclavicular joint arthrosis and SLAP type 2 lesion. MRI reports of the knees were consistent with medial and lateral meniscus tears and chondromalacia. Discussion: In his review of the records, Dr. [redacted] noted that the right knee was discussed, but the left knee was also symptomatic. He stated, "I do not understand why the involved joints would not include the left knee; reviewing the notes of the treating physician, [redacted], MD, the knees were examined and the results appear to have been bilaterally

symmetrical in all aspects." He noted further that within the cumulative trauma injury, it was clear that in Mr. [redacted] employment he frequently worked kneeling, which in Dr. [redacted]'s opinion would represent cumulative direct trauma. Dr. [redacted] felt that when the patient was MMI, he should have an added 2% WPI for this. Recommendation: The patient is a surgical candidate for his shoulders and knees.

[redacted], M.D.:

[redacted] Doctor's First Report of Occupational Injury or Illness. The patient's work history was noted. The patient was currently working for a different employer without restriction. Current complaints: 1) Bilateral shoulder pain. 2) Bilateral knee pain. Diagnoses: 1) Bilateral shoulder impingement syndrome with partial thickness rotator cuff tear. 2) Bilateral knee medial and lateral meniscus tear. Discussion: Patient suffered an industrial injury in [redacted] while working for [redacted] & [redacted]. He has continued to have pain to both shoulders and knee. He had physical therapy and acupuncture treatment which improved his symptomatology.

Deposition of [redacted]

[redacted] age deposition of the applicant. Admonitions of the deposition were given. Identification questions were asked. He was born in [redacted] He presently lived in [redacted]. He had lived in the United States for approximately [redacted] years. He lived with his wife. He had three adult children, who did not live at home. He went to the 9th grade in the United States. He did achieve a contractor's license. He had filed for bankruptcy in [redacted]. He denied being arrested or being in the military.

Besides the current cumulative trauma injury of [redacted], it was noted that he had a claim for a heel injury, but he did not know if he had filed a work claim for this.

There is mention made of a prior hearing loss claim, but it is unclear if this dated back to [redacted]. Mr. [redacted] was not sure if the hearing loss was being included in the current complaint. He thought the hearing complaint happened about five years ago.

He had been in a motor vehicle accident in [redacted] when he rear-ended a truck driven by his then-boss. He had no injuries.

He was asked to name his employers. He felt the earliest one of 10 years ago was working as a carpenter for the current company of [redacted] & [redacted]. He said his job

was at [redacted] for five years through this company. He began having a hearing loss about that time. A discussion is held about when he received his hearing aids.

He then worked at [redacted] LA for six months. Asked if he felt certain pain in his shoulders and knees, he said in his job, "when we make a certain movement, and you hurt." He had not received any medical treatment for this.
He was given jobs through his u[redacted] He said he then worked at [redacted] in [redacted] It is not clear if this was also through [redacted] & [redacted] He denied any problems there, but then said he did not recall.

He said he worked for another company on the [redacted] at [redacted] He denied having injury there but "may have" seen a doctor for shoulder and knee pain. He did not know if that was the time when he started noticing symptoms in his shoulders and knees. Later he said this was the time when he recalled having the shoulder pain, especially because the workers were on graveyard shift and it was cold.
He then worked for [redacted] for perhaps 6 months doing ADA code requirements in public schools.

Recalling the shoulder pain, he said he may have sought medical treatment but did not remember if he had. He knew that he continued to have both shoulder and knee pain while working for [redacted] He did not recall if he ever went for medical treatment.

He thought after [redacted] he worked for [redacted] Company for three months, which was in [redacted] He did not lose any time from work and felt he could perform his duties. He then returned to [redacted] & [redacted] for a job in [redacted] He continued to note knee and shoulder pain. At this time he felt he was seen at [redacted] He did not report the injury to his employer. He did not know why. He did not know he was supposed to report his injuries.

He agreed he had not suffered a specific injury but that the injury occurred over time. He then recalled that sometime during the job in [redacted] he was sent by [redacted] & [redacted] for a brief job in [redacted] and that at that time he felt his right knee snap when he picked up a piece of plywood. When this occurred he recalled going for medical care at [redacted] the day afterwards. He recalled he was given medication. He was never recommended to have surgery. He did not take the medication unless the pain was severe, which was in the course of one week.

At this time he was seen Dr. [redacted] for the past 18 months. Dr. [redacted] was treating

both his shoulders and knee.

The two attorneys discussed whether Dr. [redacted] had taken over from Dr. [redacted], with the defense attorney remarking that the applicant's orthopedic claims are denied, but his hearing loss was not.

The last time he was employed as a carpenter was on a project in [redacted]. This involved a lot of walking up and down stairs. He continued to have pain in his shoulders. He did not lose any time from work. He said he had ongoing symptoms from the [redacted] project in the right knee. He felt he "probably" saw doctors at [redacted] for this.

Regarding his left knee, he said he would get pain in one knee and then the other. He felt this was an over-compensation injury. He was not sure if his left knee started hurting after he felt the snap in his right knee.

He denied having any injuries outside of his work in any part of his body.

At this time, Dr. [redacted] had released him to return to work without restrictions.

At this time he did not have "as much (pain) as I used to," in his shoulders. He had received acupuncture and physical therapy treatment for the shoulders. He felt these alleviated his pain. He also had less knee pain. He felt his knee and shoulder pain were both at 2-3/10.

He wanted to return to work and had been looking for a job over the last three weeks. He felt that he could perform all carpentry tasks.

At this time, the lawyers confer and the deposition ends.

[redacted]

[redacted]

Listing of jobs taken by applicant as a member of the union.

This concludes the review of medical records.

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

PHYSICAL EXAMINATION:

The patient is a well-nourished, [redacted]year-old male. He is not anemic and is not jaundiced.

The patient walks with a limp on both sides.

CERVICAL SPINE:

Examination of the cervical spine reveals no swelling or ecchymosis. There is no gross tenderness noted in the trapezius muscles or scalene muscles. There is no trigger point tenderness or muscle spasm.

Deep tendon reflexes in the biceps, triceps, and brachioradialis are normal bilaterally.

Foraminal compression test is negative.

Range of motion of the cervical spine is somewhat limited in flexion and extension. Lateral flexion and rotation are normal bilaterally.

There is no motor or sensory abnormality of the upper extremities.

SHOULDERS:

The right shoulder examination reveals positive Neer's, Hawkin's, and O'Brien's test.

The left shoulder examination reveals a positive Neer's, Hawkin's, and O'Brien's test.

There is gross tenderness in the AC joint, anterior and posterior, and bicipital grooves bilaterally.

Abduction is limited in both shoulders. Range of motion is otherwise not grossly limited. Both shoulders show similar ranges of motion with 70 degrees of abduction, 40 degrees of adduction, 70 degrees of internal rotation, and 75 degrees of external rotation. Extension and forward flexion are normal.

Anterior and posterior trigger points are noted bilaterally.

There are no muscle spasms of the rhomboids or deltoids.

There is no instability of either shoulder.

Biceps test, Yergason's, and Speed tests are negative bilaterally.

Rotator cuff testing is positive, including Drop Arm, Horn Blower's, and Belly Press bilaterally.

ELBOWS:

Examination of the elbows is essentially unremarkable.

WRISTS/HANDS:

Examination of both wrists and hands is essentially unremarkable.

LUMBAR SPINE:

Examination of the lumbar spine is normal with no evidence of any neurological deficit.

Range of motion of the lumbar spine is normal.

Foraminal compression testing is negative.

Straight leg raising is to 80 degrees bilaterally.

There is no motor or sensory deficit of the lower extremities.

Deep tendon reflexes of the lower extremities are intact.

HIPS:

Examination of the hips is unremarkable.

KNEES:

Examination of both knees reveals no swelling or ecchymosis. There is no effusion of the knees.

There is crepitation of both knees. There is tenderness over the patellofemoral aspects of the knees. Patellar tenderness is also noted bilaterally. There is medial and lateral joint line tenderness of both knees.

Meniscal testing, including McMurray's, is negative bilaterally.

Lachman's and anterior drawer sign are negative bilaterally.

There are no varus or valgus deformities of either knee.

There is definite maltracking, grinding, and tilt of the patella bilaterally.

Range of motion is 110 degrees flexion and 0 degrees extension bilaterally.

DIAGNOSES:

1. Bilateral knee chronic degenerative meniscal tears of the medial and lateral menisci with evidence of chondral thinning with traumatic synovitis.

2. Bilateral shoulder chronic internal derangement with subacromial impingement, partial tears of the supraspinatus and infraspinatus, and possible tendinitis/bursitis.

DISCUSSION:

The patient worked as a carpenter for [redacted] and [redacted]nc. for many years, although I could not get the exact dates. His job was fairly heavy. He had to lift heavy weights and sometimes carry heavy weights for extended periods of time. He also did a lot of repetitive activities involving his upper and lower extremities. He initially complained of symptoms in [redacted] There is documentation that he was seen at [redacted] for his complaints. However, he did not report his symptoms as being work-related because he was afraid he would be laid off. He continued to work for this employer until sometime in late [redacted] or [redacted] again the dates are not clear. He has subsequently continued to work for other employers, but indicates lighter duty activities. He also reports some employment for brief periods during this employment with

[redacted] and [redacted] but denies interim injuries.

The MRI's that were reviewed showed that he has multiple degenerative changes in the knee joints and shoulders joints bilaterally. He has evidence of supraspinatus and infraspinatus tendinosis. There are partial tears of the rotator cuffs and partial tears of the menisci and entire knee joints on both sides.

At the current time, the patient is not significantly bothered by knee or shoulder pains. He states he cannot do activities of daily living without difficulty, but avoids overhead reaching and kneeling and squatting when possible.

The diagnoses are based on the MRI findings from [redacted] There are no new MRI's provided for my review at this time.

The patient's ongoing treatment is unclear as from which I can tell he has not seen a doctor in some time.

With regard to the knees, there are positive signs of medial and lateral joint line tenderness. Of interest, there is no gross limitation of range of motion in the shoulders, except abduction, or the knees. However, he does have MRI findings consistent with the clinical findings. He has rotator cuff signs of Belly Press and abduction. He has full internal and external rotation of the shoulders.

At this time the patient does not indicate he wants any type of surgical intervention. Therefore, surgical intervention should be deferred, rather than doing it at the present time.

He is considered at MMI status as of the date he last sought treatment, which appears to have been in [redacted]

I see no indication of any period of TTD as it appears he has continued to work, just adjusting his work activities with subsequent employers.

CURRENT STATUS:

The patient has reached permanent and stationary/MMI status with regards to both shoulders and both knees.

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

AMA IMPAIRMENT:

Using the AMA Guides, Fifth Edition:

For the bilateral shoulders he is given impairment due to the lack of motion in abduction using figure 16-43. The shoulders are given 5% upper extremity impairment for each side, which using Table 16-3 gives him 3% whole person for each side - totaling 6% for the shoulders.

Similarly, the knees show degenerative joint changes, meniscal changes, and traumatic synovitis that limit his ambulatory capacity, repetitive heavy weight lifting, and squatting, pushing, and pulling-type maneuvers. Going up and down stairs would be difficult for him. Taking all of this into consideration, he is given rated using Table 17-33 similar to a partial medial and lateral meniscectomy, with a 4% WPI for each knee, totaling 8%.

His total whole person impairment is 14%.

FUTURE MEDICAL CARE:

For a flare-up and allowance for future care is indicated. This would be brief physical therapy, and the use of anti-inflammatory medication, and possibly arthroscopic debridement of both knees and shoulders. However, I would only do arthroscopic surgery if he has a significant amount of pain and limitation of range of motion and function.

At the present time, the patient is not willing to have any type of surgical intervention. I do not believe surgery is necessary at this time as he is able to function adequately.

CAUSATION:

A detailed history obtained from the patient indicated that he worked as a carpenter and had to carry heavy weights, do repetitive squatting, and use of both upper extremities with power saws, grinders, etc. His complaints are noted in the records from [redacted] in starting in [redacted] There is no question that this patient has definite evidence of constant repetitive type of injuries to his shoulders and knees. I do feel he reasonably sustained injuries on a cumulative trauma basis with [redacted] and [redacted]

I will not comment on his hearing loss, as this is beyond the scope of my practice.

However, this should be evaluated by an ENT or audiologist to determine this cause and any impairment.

APPORTIONMENT:

Although he has fairly degenerative changed in the knees and shoulders, this appears to be attributable to his work at [redacted] and [redacted] on a CT basis. In the absence of records that indicate any injuries with another employer, I would apportion his disability 100% to his work at [redacted] and [redacted] during the CT period.

DISCLOSURE:

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

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

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

Yours sincerely,

[redacted]

DIVAKAR KRISHNAREDDY, M.D.
Diplomate, American Board of Orthopedic Surgery

Signed in Los Angeles County on this date [redacted]

[redacted]

DIVAKAR KRISHNAREDDY, M.D.

Diplomate, American Board of Orthopedic Surgery

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

SAMPLE

[redacted]

CITY OF XXXXXXXXXXXX
DEPARTMENT OF XXXXXXXXXXXXX PENSIONS
XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX

Attn: XXXXXXXXXXXX, [redacted]

CLAIMANT : [redacted]
CLAIM NO :
EMPLOYER :
ACCT NO :
D/EXAMIN :

ORTHOPEDIC EVALUATION – DEPARTMENT OF PENSIONS

Dear Mr. XXXXXXX:

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

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

EMPLOYMENT AT TIME OF INCIDENT:

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

[redacted]

HISTORY OF THE PRESENT INJURY:

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

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

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

He was treated with physical therapy and injections.

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

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

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

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

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

[redacted]

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

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

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

PRESENTING COMPLAINTS:

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

The bilateral elbows. There is tenderness over the scar. The pain increases with a lot of use and cold weather. Lifting particularly away from his body causes pain.

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

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

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

PAST MEDICAL HISTORY:

[redacted]

WORK INJURIES:

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

ILLNESSES:

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

MEDICATIONS:

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

ALLERGIES:

None.

SURGERIES:

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

AUTO ACCIDENTS:

Denied any with injuries.

SOCIAL HISTORY:

The patient denies smoking cigarettes or drinking alcoholic beverages.

FAMILY HISTORY:

[redacted]

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

REVIEW OF MEDICAL RECORDS:

City of XXXXX: [redacted] XXXXXXXXXX, [redacted] Cover letter reviewed.

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

PHYSICAL EXAMINATION:

GENERAL:

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

GAIT:

The patient has an antalgic gait on the right side.

He is wearing a right knee brace.

STANCE:

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

CERVICAL SPINE:

The patient complains of right and left paraspinal tenderness.

There are no fascial nodules.

Trapezii are nontender without spasms.

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

Foraminal compression test is negative.

[redacted]

SHOULDERS:

There are no trigger points present.

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

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

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

ELBOWS:

There are well healed lateral scars that are diffusely tender.

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

Cubital tunnels are nontender.

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

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

WRISTS/HANDS:

Forearms are nontender.

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

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

[redacted]

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

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

There is no evidence of thenar or hypothenar atrophy.

Abduction strength is strong.

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

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

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

Jamar Grip Strength Testing

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

UPPER EXTREMITY MEASUREMENTS:

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

LUMBAR SPINE:

Examination of the lumbosacral spine reveals some local spasms noted in the lower lumbar spine, especially on the left side. There is trigger point tenderness, mostly in the lumbosacral paravertebral muscles, posterior thigh, and gluteal muscles on the right.

Range of motion of the lumbar spine reveals the patient bends forward to the level of -2" above the ankles and back to the erect position quickly and easily. Lateral tilt is to 20/20

[redacted]

degrees with ispilateral pain. There is no radiating pain in the lower extremities. Extension is to 20 degrees.

LOWER EXTREMITIES:

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

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

The extensor halluces longus is strong.

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

Straight leg raising to 60/60 degrees.

Sciatic tension test is negative.

LEFT KNEE:

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

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

RIGHT KNEE:

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

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

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

BILATERAL FEET:

Examination of the feet and ankles is essentially unremarkable, except there is mild plantar

[redacted]

fascial tenderness bilaterally.

LOWER EXTREMITY MEASUREMENTS:

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

DIAGNOSIS:

1. Degenerative arthritis of the right knee, status post surgery times three.
2. Cervical spine degenerative disc disease.
3. Lumbar spine degenerative disc disease.
4. Bilateral lateral epicondylitis, status post extensor release and debridement.
5. Bilateral plantar fasciitis.

DISCUSSION:

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

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

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

[redacted]

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

With regard to the feet he has bilateral plantar fasciitis that he states developed in [redacted] having treatment in [redacted] while he was on desk duty. There is no mechanism of injury of this being related to his job.

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

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

INCIDENTS CAUSING IMPAIRMENT:

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

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

The right knee is due to a combination of the degeneration and due to the injury in the Army and surgeries of the [redacted] with significant aggravation due to his employment in the episodes of [redacted] and further in the two episodes of [redacted] The episode of 1998 aggravated preexisting arthritis. The episodes of [redacted] further aggravated the preexisting arthritis that would have existed without his employment. However, the significant arthritis seen is due to the cartilage damage in the [redacted]

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

[redacted]

beginning with a change in shoes in [redacted] but show the symptoms probably beginning in [redacted] while he was working a sedentary job as a detective.

PRESENT IMPAIRMENT:

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

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

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

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

MEDICAL REHABILITATION:

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

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

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

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

DISCLOSURE:

Mr. xxxxxxxxxx was interviewed and examined by the undersigned; the medical records were reviewed; and this dictation was done in its entirety by the undersigned.

[redacted]

Yours sincerely,

DIVAKAR KRISHNAREDDY, M.D.
Diplomate, American Board of Orthopedic Surgery

Signed in Los Angeles County on this date _____

[redacted]

DIVAKAR KRISHNAREDDY, M.D.

Diplomate, American Board of Orthopedic Surgery

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

SAMPLE

March 26, [redacted]

LAW OFFICES [redacted]
[redacted] N. Brand Blvd, Suite [redacted]
Glendale, CA [redacted]
Attn: [redacted], Esq.

and

[redacted] AND [redacted]
[redacted] Atlantic Avenue
Long Beach, CA [redacted]
Attn: [redacted], Esq.

RE: [redacted] VS. [redacted] INC.

CLAIMANT	:	[redacted]
WCAB NO	:	ADJ[redacted]
CLAIM NO	:	00[redacted]-WC-01
EMPLOYER	:	[redacted] AND [redacted], INC.
ACCT. NO	:	[redacted]
D/INJURY	:	01/[redacted]
D/EXAMIN	:	03/[redacted]

ORTHOPEDIC PANEL QME EVALUATION

Dear Ms. [redacted] and Mr. [redacted]

Today, I had the opportunity to perform an Orthopedic Panel QME Evaluation in my Arcadia office on [redacted], a [redacted]-year-old, right-handed male. He gives me the following history directly. Medical records are also supplied which I have had the opportunity to review.

EMPLOYMENT:

RE: V[redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

The patient worked as a carpenter for [redacted] & [redacted] for approximately many years prior to his onset of orthopedic symptoms. He is unclear of the exact date he began working for this employer, but states it was many years. He did various construction jobs through this employer. It appears he last worked for this employer a few years ago.

He is presently working for a different employer, [redacted] Inc, performing a commercial job as a safety worker. He does not do any significant lifting, pushing, pulling, or squatting activities. Essentially, he is doing somewhat limited duty work. He is not doing the type of work he was doing previously. He states he intermittently performed work for several other constructions companies during brief periods of lay off from [redacted] & [redacted], but denies any injures with those employers.

HISTORY OF PRESENT INJURY:

The patient states he first injured his right knee as a result of throwing wood into a trash dumpster when he twisted as he was throwing the trash inside. This was sometime around [redacted]. He states that around that same time he began to have pain in his shoulders due to the amount of lifting and overhead activities he had to do in constructions. As he continued to work he also developed the onset of left knee pains.

He was first seen for treatment in [redacted] with complaints of shoulder and knee pain and also some hearing problems. He states he treated at [redacted] on and off for pains in his knees and shoulders for a few years.

He received about 10 months of physical therapy and acupuncture, as well as took medications.

He later came under the care of Dr. [redacted] who then ordered MRIs of his knees and shoulders. He was also referred to an ENT for his hearing problems.

He states he continued to work, but his knees and shoulders go progressively worse. He then was referred to Dr. [redacted] He was told he studies were abnormal and may need surgery.

He was laid off from [redacted] and [redacted] and indicates after that he worked for a few other companies, but tried to do lighter work, so he could continue to work.

He is no longer under treatment and thinks it has been about 18 months since he last had treatment.

PRESENT COMPLAINTS:

Bilateral shoulder pain. He states he is able to do "everything" but has increased pain with any attempt at reaching or stretching his arms above his shoulders.

Bilateral knee pains. Again, he states he can do all activities, but has increase pain with cold weather, and he avoids kneeling and squatting.

PAST MEDICAL HISTORY:

WORK INJURIES:

None prior that he can recall. He reports only the hearing problems.

ILLNESSES:

Hypercholesterolemia.

MEDICATIONS:

None.

ALLERGIES:

None.

SURGERIES:

Heel spurs.

AUTOMOBILE ACCIDENTS:

Denied with any injures.

SOCIAL HISTORY:

The patient does not smoke cigarettes. He drinks three beers daily.

FAMILY HISTORY:

Noncontributory.

REVIEW OF MEDICAL RECORDS:

Mor[redacted]

[redacted]. Faxed copy of Cover letter noting I am to see the patient on [redacted]for a Panel QME. Notes he was employed as carpenter and is claim CT to the knees, shoulders and hearing loss. Claim was denied.

[redacted] &

[redacted]: [redacted] M. [redacted] Cover letter noting I am to see the applicant on [redacted] This is a cumulative trauma injury while working as a carpenter from 01/[redacted] with claims for bilateral shoulder, bilateral knees and industrial basis ears/hearing loss.

[redacted]

[redacted] State of California, Division of Workers Compensation/Workers Compensation Appeals Board Application for Adjudication of Claim. Claimed is cumulative trauma injury from [redacted] with injuries to ear, shoulders and knee (patella) from exposure to loud construction noise, repetitive pulling, heavy lifting, carrying, kneeling, climbing hammering.

[redacted]

[redacted]: Comprehensive Industrial Medical-Legal Otolaryngologic Evaluation. Hearing loss evaluation. Ratable hearing loss of 25%.

[redacted] M.D.:

[redacted] Doctor's First Report of Occupational Injury or Illness. Seen for injury of [redacted] which patient indicated at occurred at work when he fell against the blunt

end of a pole. Pain rated as 3/10. Chest x-ray was negative. Diagnoses: Contusion of chest wall, right ribs. Prescription for naproxen 220 mg, rib belt, dispensed hot/cold pack.

[redacted] Chief complaint of slipping on "brace rob" with resultant injuring of ribs, now with rib pain. Diagnosis: Contusion of chest wall, right ribs, resolved. Plan: Released from care. Impairment rating: 0%.

[redacted]

[redacted], Safety Representative. Employer's Report of Occupational Injury or Illness. Employee was carrying wood when prybar slipped and he hit metal turn-buckle, injuring ribs.

[redacted] D.:

[redacted] and [redacted]: Radiology/Diagnostics. Audiometry on [redacted] hearing loss.

K[redacted]

20[redacted]:

[redacted], M.D. Health Maintenance Exam. Complaining of foot pain. History of heel pain with pain on active exercise. Also history of finger injury with limited range of motion noted of left index finger. Noted hand laceration. Diagnoses: 1) Heel pain. 2) Dizziness. Heel cup ordered. Labs ordered.

20[redacted]:

[redacted] Patient complains of knee pain when jogging as well as chest discomfort when working or pushing. Also complains of bilateral shoulder pain, scalp problem and hearing problem. He has refused therapy. Diagnoses: 1) Chest pain. 2) Hyperlipidemia. 3) Seborrheic dermatitis. 4) Shoulder joint pain. 5) Tinnitus. Labs taken showing abnormal EKG and elevated TSH.

[redacted] Plan: Labs.

[redacted] P.A. Office visit: Patient is a [redacted]ear old male who

sustained a left knee injury three days before. Mechanism of injury: Fall. Also complains of right heel pain as well as dizziness. He had heel spur surgery before. Diagnoses: 1) Dizziness. 2) Heel pain. Diagnoses: 1) Osteoarthritis of knee. 2) Strain of knee. Plan: X-ray of left knee. Labs.

[redacted] M.D. X-ray of left knee. Impression: No significant abnormality.

[redacted] Office visit: Patient complains of right foot pain and right knee pain. He already changed shoes, but it is still painful. Because of such, he has been off balance and feels that knee also has an ache. Requesting for cream for his feet and erectile dysfunction.

Also notes on hearing tests, treadmill, audiometry, angina, erectile dysfunction, prediabetes, onychomycosis, essential hypertension.

20[redacted]:

[redacted] M.D. Patient presents for annual visit. Complains of right foot pain, right shoulder pain greater than 3 months, right knee pain more than 3 months. Patient noted to be noncompliant with meds. Diagnoses: 1) Hyperlipidemia. 2) Chronic right foot pain. 3) Right shoulder joint pain for more than 3 months. 4) Right knee joint pain for greater than 3 months.

[redacted] M.D. X-ray of right knee. Impression: 1) Exostosis from the right proximal fibula. 2) Mild degenerative changes.

[redacted]. X-ray of right shoulder. Impression: 1) Moderate degenerative changes at the AC joint.

[redacted] X-ray of right foot. Impression: Within normal limits however calcaneal spurs noted.

[redacted] M.D. Complaining of right knee pain at 8/10, started day before right after work. Just started working construction after having been off a few weeks. Asking for disability. Told that if he wants full disability, needs to get disability lawyer. Diagnosis: Right knee pain. Plan: 1) Use ibuprofen for pain. 2) Refer to physical therapy for knee. 3) Advised to find disability lawyer for permanent disability.

4) Return if symptoms worsen.

[redacted], P.T. Physical Therapy Evaluation for right knee.

Also noted are diagnoses for hyperlipidemia and prediabetes.

[redacted] Medical Center:

[redacted] M.D. Initial Comprehensive Primary Treating Physician's Report. Patient is a [redacted] year-old male, who has been working as a Carpenter for [redacted] & [redacted], Inc for [redacted] years. His usual and customary duties consisted of building frames, organizing and handling equipment. The physical demands of his job consisted of performing repetitive pulling, lifting, carrying, kneeling, climbing and using heavy equipment in a frequency of 7-10 hours per day. He was also exposed to noise. The patient stated that during the period from [redacted] he sustained cumulative type of injuries, as a result of which, he developed pain in his ears, shoulders and knees. He noted gradual onset of pain in his ears, shoulders and knees. He never reported the injuries since he was afraid of losing his job. He sought medical care on his own at [redacted] where he was evaluated, underwent x-rays and was prescribed pain medications. Present complaints: 1) Hearing loss. 2) Burning bilateral shoulder pain radiating down the arms to the fingers, associated with muscle spasms. The pain is aggravated by gripping, grasping, reaching, pulling, lifting, and doing work at or above the shoulder level. 3) Bilateral knee pain and muscle spasms. The pain is aggravated with squatting, kneeling, ascending or descending stairs, prolonged positioning including weight bearing, standing, and walking as well as numbness, tingling, and pain radiating to the feet. Pain is alleviated with medications, rest and activity restriction. Diagnoses: 1) Hearing loss. 2) Bilateral shoulder sprain/strain rule out internal derangement. 3) Bilateral knee sprain/strain rule out internal derangement. Plan: Medication prescriptions given: Fanatrex, cyclobenzaprine, synapryn, ketoprofen cream, deprizine, tabradol, dicopanol. 2) Authorization for x-rays and MRIs. 3)TENS unit with supplies for home use. 4) Physiotherapy and shockwave therapy. 5) Functional capacity evaluation. 6) ENT referral. 7) EMG/NVC testing. Work status: TTD from [redacted], although Dr. [redacted] noted that he did this without having a job description. Should he have one and the patient be able to work, he would place patient on modified duties.

[redacted]: Dr. [redacted] PR-2: No change in symptoms, diagnoses or plan.

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

[redacted] Dr. [redacted] PR-2: Patient complains of hearing loss, bilateral shoulder pain radiating down the arms to the fingers associated with muscle spasms and bilateral knee pain and spasm. He also complains of numbness, tingling and pain radiating to the feet. The patient states that the symptoms persist, but the medications do offer him temporary relief of pain and improve his ability to have restful sleep.Diagnoses: 1) Hearing loss. 2) Bilateral shoulder sprain/strain rule out internal derangement. 3) Bilateral knee sprain/strain rule out internal derangement. Plan: Continue meds. Referral to orthopedic surgeon for bilateral shoulders and knees. PRP treatment for bilateral shoulders and knees. Work Status: TTD.

[redacted]: Dr. [redacted] PR-2. No change in symptomatology, diagnoses or plan.

[redacted] Dr. [redacted] PR-2 Report. No change in symptoms or diagnoses. Referred to ENT. PRP treatment. Follow-up in four weeks. Work Status: TTD

[redacted] PR-2. Diagnoses: 1) Bilateral shoulder internal derangement. 2) Bilateral knee internal derangement. Plan: Continue medications. Work Status: TTD.

[redacted]: Dr. [redacted] No change in symptomatology or diagnoses. Referral for ENT and orthopedic evaluations. Referred for EMG/NV of bilateral upper and lower extremities. Physical therapy, acupuncture and chiropractic treatment 3 x 6 weeks. Continued medications. Work Status: TTD

[redacted], M.D. Ortho. PR-2 Report. No change in symptoms or diagnoses. Plan: MRIs of the bilateral shoulders and knees. Physical therapy, acupuncture and chiropractic treatment 3 x 6 weeks. Continue medications.

[redacted] M.D. Ortho. PR-2 Report. Cumulative trauma injury of [redacted] No change in symptoms or diagnoses. Plan including request for physical therapy, chiropractic treatment and acupuncture 3 x 6 weeks and now shockwave therapy as well as orthopedic referral. Work Status: TTD.

[redacted] Dr. [redacted] PR-2. Diagnoses: 1) Hearing loss. 2) Sprain of left rotator cuff capsule. 3) Unspecified derangement of shoulder, right. 4) Tear, medial meniscus, bilateral knee. 5) Tear, lateral meniscus, bilateral knee. Dr. [redacted] continued with Dr. Johnson's plans.

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

[redacted] Dr. [redacted] No change in symptoms, diagnoses or plans.

[redacted] Dr. [redacted] Complaints of bilateral knee pain at 7/10 and bilateral shoulder pain at 7/10. Diagnoses: 1) Hearing loss. 2) Sprain of left rotator cuff capsule. 3) Unspecified derangement of shoulder, right. 4) Tear, medial meniscus, bilateral knee. 5) Tear, lateral meniscus, bilateral knee. Plan: Continue medications.

[redacted]maging Medical Grou[redacted]

[redacted] M.D. MRI of the Right Shoulder: Impression: 1) Laterally downsloping, flat acromion. 2) Osteoarthritis of acromioclavicular joint. 3) Partial-thickness tear of the supraspinatus. 4) Partial-thickness tear of the infraspinatus. 5) Synovial effusion. 6) Subacromial/subdeltoid bursitis. 7) Subcortical cysts in the humeral head. 8)SLAP type II lesion of the glenoid. 9) Partial thickness tear of the biceps tendon. 10) Partial thickness tear of the subscapularis

[redacted] Dr. [redacted] MRI of the Left Shoulder. Impression: 1) Laterally downsloping, flat acromion. 2) Osteoarthritis of acromioclavicular joint. 3) Partial-thickness tear of the supraspinatus. 4) Partial-thickness tear of the infraspinatus. 5) Synovial effusion. 6) Subacromial subdeltoid bursitis. 7) Subcortical cysts in the humeral head. 8) SLAP type II lesion of the glenoid. 9) Partial-thickness tear of the biceps tendon. 10) Partial-thickness tear of the subscapularis.

[redacted] Dr. [redacted] MRI of the Right Knee. Impression: 1) Horizontal tear involving the posterior horn of the medial meniscus. 2) Complex tear involving the anterior horn of the lateral meniscus. 3) Linear increased signal in the posterior horn of the lateral meniscus, likely reflects internal degeneration but a tear of the posterior horn is not excluded. 4) Lateral collateral ligament complex sprain versus partial-thickness tear. 5) Patellar chondromalacia. 6) Knee joint effusion

[redacted], M.D. MRI of the Left Knee. Impression: 1) Medial meniscus tear, posterior horn and body segments; the body of the meniscus is partially extruded out of the joint space. 2) Lateral meniscus tear, anterior horn; type II myxoid (composed of clear, mucoid substance, i.e., resembling mucus) change, posterior horn partially discoid lateral meniscus. 3) Semimembranosus tendinosis. 4) Partial tear of posterior cruciate ligament. 5) Patella chondromalacia, grade 3. 6) Medial femorotibial joint space narrowing and osteoarthritis.

[redacted], [redacted] M.D. Radiology. Right Shoulder MRI. Impression: Supraspinatus partial tendon tear. Infraspinatus partial tendon tear, with associated 19 mm proximal peritendinous cyst. Subscapularis partial tendon tear. Moderate to marked teres minor muscle atrophy. Biceps partial tendon tear, horizontal and vertical segments, tenosynovitis. Superior glenoid labral tear, SLAP type II configuration. Subdeltoid bursitis. Acromioclavicular joint and glenohumeral joint arthrosis. Subcortical cyst in the humeral head.

[redacted] Dr. [redacted] Left Shoulder MRI. Impression: 1) Supraspinatus and infraspinatus tendon tears. 2) Subscapularis tendinosis. 3) Teres minor muscle atrophy. 4) Superior glenoid labral tear, SLAP type II configuration. 5) Biceps tendon tears, horizontal and vertical segments. 6) Biceps tenosynovitis. 7) Subdeltoid bursitis. 8) Acromioclavicular joint and glenohumeral joint arthrosis.

[redacted] Dr. [redacted] MRI of Right Knee. Impression: 1) Complex tears, posterior horn and body segment of the medial meniscus. 2) Displaced tear involving the anterior horn of the lateral meniscus, with centrally displaced fragment adjacent to the lateral tibial spine. 3) Complex tear, body segment; cleavage tear, posterior horn. 4) Semimembranosus tendinosis. 5) Pes anserine bursitis. 6) Popliteus tendinosis. 7) Medial and lateral femorotibial joint arthrosis. 8) Patellar chondromalacia, grade 2/3.

[redacted]naging Medical Group[redacted].:

[redacted] X-ray of Right Shoulder. Impression: Calcification projecting over the lateral humeral head which may reflect calcific tendinosis.

[redacted] X-ray of Right Knee. Impression: 1) Sclerosis, medial tibial articular surface with associated medial compartment joint space narrowing. 2) Osteophytes of posterior aspect of patellar upper and lower poles. 3) Exophytic bony mass arising from the metaphyseal region of the proximal fibula in its posteromedial aspect.

[redacted] X-ray of Left Knee. Impression: 1) Sclerosis of the medial tibial articular surface, with associated medial compartment joint space narrowing. 2) Osteophytes off the posterior aspect of the patellar upper and lower poles. 3) Enthesophyte off the upper patellar pole anteriorly.

[redacted] M.D.:

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

[redacted] Discovery reports including evaluation of acromioclavicular and knee joints.

[redacted]: Anatomical Impairment Measurements (AiM) Report.

[redacted] Orthopedic Medical Clinics, [redacted] M.D.:

[redacted] Initial Comprehensive Primary Treating Physician Report. The patient's work history was noted. He appears to have been referred to Dr. [redacted] Dr. [redacted]. He complained of bilateral shoulder and knee pain. Diagnoses: 1) Hearing loss. 2) Sprain of left rotator cuff capsule. 3) Unspecified derangement of shoulder, right. 4) Tear, medial meniscus, bilateral knee. 5) Tear, lateral meniscus, bilateral knee. Plan: Continue medications. Plan: Continue medications prescribed by Dr. [redacted]. Referral for orthopedic surgeon consult for left shoulder and bilateral knees. Referral to ENT specialist. Patient to have physical therapy, acupuncture and chiropractic treatment. Work Status: TTD.

[redacted], M.D.

[redacted] Qualified Medical Evaluation Report. Dr. [redacted] reviewed the patient's history. Past history of bone spur and hearing loss. Dr. [redacted] said patient had undergone physical therapy and acupuncture for bilateral knee and shoulder which had not been helpful. In his activities of daily living he denied all problems with ADLs except for sleep. This included no problems with standing, walking, stair climbing and reaching overhead. Patient was observed to walk with an antalgic gait to the right. Dr. [redacted] noted the patient to be vague and ambiguous during the examination. He wondered how truthful the patient was being. Diagnoses: Dr. [redacted] was noted not to give diagnoses, but instead referred the reader to the MRI results. Discussion: Dr. [redacted] indicated that the patient reported drinking one to two beers a day. His cumulative trauma injury was from [redacted] but there were no reports on the shoulders or knees until [redacted]. Therefore, cumulative trauma for the knees and shoulders should be on this date and not earlier. Findings were consistent with partial thickness tear, bilateral shoulders, rotator cuff tendons and biceps tendon with acromioclavicular joint arthrosis and SLAP type 2 lesion. MRI reports of the knees were consistent with medial and lateral meniscus tears and chondromalacia. Discussion: In his review of the records, Dr. [redacted] noted that the right knee was discussed, but the left knee was also symptomatic. He stated, "I do not understand why the involved joints would not include the left knee; reviewing the notes of the treating physician, [redacted], MD, the knees were examined and the results appear to have been bilaterally

symmetrical in all aspects." He noted further that within the cumulative trauma injury, it was clear that in Mr. Luna's employment he frequently worked kneeling, which in Dr. [redacted]'s opinion would represent cumulative direct trauma. Dr. [redacted] felt that when the patient was MMI, he should have an added 2% WPI for this. Recommendation: The patient is a surgical candidate for his shoulders and knees.

[redacted] M.D.:

[redacted] Doctor's First Report of Occupational Injury or Illness. The patient's work history was noted. The patient was currently working for a different employer without restriction. Current complaints: 1) Bilateral shoulder pain. 2) Bilateral knee pain. Diagnoses: 1) Bilateral shoulder impingement syndrome with partial thickness rotator cuff tear. 2) Bilateral knee medial and lateral meniscus tear. Discussion: Patient suffered an industrial injury in [redacted] while working for [redacted] & [redacted]. He has continued to have pain to both shoulders and knee. He had physical therapy and acupuncture treatment which improved his symptomatology.

Deposition of [redacted]

[redacted] age deposition of the applicant. Admonitions of the deposition were given. Identification questions were asked. He was born in [redacted]s, Mexico. He presently lived in El Monte. He had lived in the United States for approximately [redacted] years. He lived with his wife. He had three adult children, who did not live at home. He went to the 9th grade in the United States. He did achieve a contractor's license. He had filed for bankruptcy in [redacted]. He denied being arrested or being in the military.

Besides the current cumulative trauma injury of [redacted], it was noted that he had a claim for a heel injury, but he did not know if he had filed a work claim for this.

There is mention made of a prior hearing loss claim, but it is unclear if this dated back to [redacted]. Mr. [redacted] was not sure if the hearing loss was being included in the current complaint. He thought the hearing complaint happened about five years ago.

He had been in a motor vehicle accident in 20[redacted] when he rear-ended a truck driven by his then-boss. He had no injuries.

He was asked to name his employers. He felt the earliest one of [redacted] years ago was working as a carpenter for the current company of [redacted] & [redacted]. He said his job

was at [redacted] for five years through this company. He began having a hearing loss about that time. A discussion is held about when he received his hearing aids.

He then worked at [redacted] LA for six months. Asked if he felt certain pain in his shoulders and knees, he said in his job, "when we make a certain movement, and you hurt." He had not received any medical treatment for this.
He was given jobs through his u[redacted] He said he then worked at California [redacted] in Pasadena. It is not clear if this was also through [redacted] & [redacted] He denied any problems there, but then said he did not recall.

He said he worked for another company on the [redacted] at LAX. He denied having injury there but "may have" seen a doctor for shoulder and knee pain. He did not know if that was the time when he started noticing symptoms in his shoulders and knees. Later he said this was the time when he recalled having the shoulder pain, especially because the workers were on graveyard shift and it was cold.
He then worked for [redacted] for perhaps 6 months doing ADA code requirements in public schools.

Recalling the shoulder pain, he said he may have sought medical treatment but did not remember if he had. He knew that he continued to have both shoulder and knee pain while working for [redacted] He did not recall if he ever went for medical treatment.

He thought after [redacted] he worked for [redacted] Company for three months, which was in [redacted] He did not lose any time from work and felt he could perform his duties. He then returned to [redacted] & [redacted] for a job in [redacted] He continued to note knee and shoulder pain. At this time he felt he was seen at [redacted] He did not report the injury to his employer. He did not know why. He did not know he was supposed to report his injuries.

He agreed he had not suffered a specific injury but that the injury occurred over time. He then recalled that sometime during the job in Irvine, he was sent by [redacted] & [redacted] for a brief job in Los Angeles and that at that time he felt his right knee snap when he picked up a piece of plywood. When this occurred he recalled going for medical care at [redacted] the day afterwards. He recalled he was given medication. He was never recommended to have surgery. He did not take the medication unless the pain was severe, which was in the course of one week.

At this time he was seen Dr. [redacted] for the past 18 months. Dr. [redacted] was treating

both his shoulders and knee.

The two attorneys discussed whether Dr. [redacted] had taken over from Dr. [redacted], with the defense attorney remarking that the applicant's orthopedic claims are denied, but his hearing loss was not.

The last time he was employed as a carpenter was on a project in [redacted]. This involved a lot of walking up and down stairs. He continued to have pain in his shoulders. He did not lose any time from work. He said he had ongoing symptoms from the [redacted] project in the right knee. He felt he "probably" saw doctors at [redacted] for this.

Regarding his left knee, he said he would get pain in one knee and then the other. He felt this was an over-compensation injury. He was not sure if his left knee started hurting after he felt the snap in his right knee.

He denied having any injuries outside of his work in any part of his body.

At this time, Dr. [redacted] had released him to return to work without restrictions.

At this time he did not have "as much (pain) as I used to," in his shoulders. He had received acupuncture and physical therapy treatment for the shoulders. He felt these alleviated his pain. He also had less knee pain. He felt his knee and shoulder pain were both at 2-3/10.

He wanted to return to work and had been looking for a job over the last three weeks. He felt that he could perform all carpentry tasks.

At this time, the lawyers confer and the deposition ends.

[redacted]

[redacted] Carpenters:

Listing of jobs taken by applicant as a member of the union.

This concludes the review of medical records.

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

PHYSICAL EXAMINATION:

The patient is a well-nourished, [redacted]year-old male. He is not anemic and is not jaundiced.

The patient walks with a limp on both sides.

CERVICAL SPINE:

Examination of the cervical spine reveals no swelling or ecchymosis. There is no gross tenderness noted in the trapezius muscles or scalene muscles. There is no trigger point tenderness or muscle spasm.

Deep tendon reflexes in the biceps, triceps, and brachioradialis are normal bilaterally.

Foraminal compression test is negative.

Range of motion of the cervical spine is somewhat limited in flexion and extension. Lateral flexion and rotation are normal bilaterally.

There is no motor or sensory abnormality of the upper extremities.

SHOULDERS:

The right shoulder examination reveals positive Neer's, Hawkin's, and O'Brien's test.

The left shoulder examination reveals a positive Neer's, Hawkin's, and O'Brien's test.

There is gross tenderness in the AC joint, anterior and posterior, and bicipital grooves bilaterally.

Abduction is limited in both shoulders. Range of motion is otherwise not grossly limited. Both shoulders show similar ranges of motion with 70 degrees of abduction, 40 degrees of adduction, 70 degrees of internal rotation, and 75 degrees of external rotation. Extension and forward flexion are normal.

Anterior and posterior trigger points are noted bilaterally.

There are no muscle spasms of the rhomboids or deltoids.

There is no instability of either shoulder.

Biceps test, Yergason's, and Speed tests are negative bilaterally.

Rotator cuff testing is positive, including Drop Arm, Horn Blower's, and Belly Press bilaterally.

ELBOWS:

Examination of the elbows is essentially unremarkable.

WRISTS/HANDS:

Examination of both wrists and hands is essentially unremarkable.

LUMBAR SPINE:

Examination of the lumbar spine is normal with no evidence of any neurological deficit.

Range of motion of the lumbar spine is normal.

Foraminal compression testing is negative.

Straight leg raising is to 80 degrees bilaterally.

There is no motor or sensory deficit of the lower extremities.

Deep tendon reflexes of the lower extremities are intact.

HIPS:

Examination of the hips is unremarkable.

KNEES:

Examination of both knees reveals no swelling or ecchymosis. There is no effusion of the knees.

There is crepitation of both knees. There is tenderness over the patellofemoral aspects of the knees. Patellar tenderness is also noted bilaterally. There is medial and lateral joint line tenderness of both knees.

Meniscal testing, including McMurray's, is negative bilaterally.

Lachman's and anterior drawer sign are negative bilaterally.

There are no varus or valgus deformities of either knee.

There is definite maltracking, grinding, and tilt of the patella bilaterally.

Range of motion is 110 degrees flexion and 0 degrees extension bilaterally.

DIAGNOSES:

1. Bilateral knee chronic degenerative meniscal tears of the medial and lateral menisci with evidence of chondral thinning with traumatic synovitis.

2. Bilateral shoulder chronic internal derangement with subacromial impingement, partial tears of the supraspinatus and infraspinatus, and possible tendinitis/bursitis.

DISCUSSION:

The patient worked as a carpenter for [redacted] and [redacted]nc. for many years, although I could not get the exact dates. His job was fairly heavy. He had to lift heavy weights and sometimes carry heavy weights for extended periods of time. He also did a lot of repetitive activities involving his upper and lower extremities. He initially complained of symptoms in [redacted] There is documentation that he was seen at [redacted] for his complaints. However, he did not report his symptoms as being work-related because he was afraid he would be laid off. He continued to work for this employer until sometime in late [redacted] or [redacted] again the dates are not clear. He has subsequently continued to work for other employers, but indicates lighter duty activities. He also reports some employment for brief periods during this employment with

[redacted] and [redacted] but denies interim injuries.

The MRI's that were reviewed showed that he has multiple degenerative changes in the knee joints and shoulders joints bilaterally. He has evidence of supraspinatus and infraspinatus tendinosis. There are partial tears of the rotator cuffs and partial tears of the menisci and entire knee joints on both sides.

At the current time, the patient is not significantly bothered by knee or shoulder pains. He states he cannot do activities of daily living without difficulty, but avoids overhead reaching and kneeling and squatting when possible.

The diagnoses are based on the MRI findings from [redacted] There are no new MRI's provided for my review at this time.

The patient's ongoing treatment is unclear as from which I can tell he has not seen a doctor in some time.

With regard to the knees, there are positive signs of medial and lateral joint line tenderness. Of interest, there is no gross limitation of range of motion in the shoulders, except abduction, or the knees. However, he does have MRI findings consistent with the clinical findings. He has rotator cuff signs of Belly Press and abduction. He has full internal and external rotation of the shoulders.

At this time the patient does not indicate he wants any type of surgical intervention. Therefore, surgical intervention should be deferred, rather than doing it at the present time.

He is considered at MMI status as of the date he last sought treatment, which appears to have been in [redacted]

I see no indication of any period of TTD as it appears he has continued to work, just adjusting his work activities with subsequent employers.

CURRENT STATUS:

The patient has reached permanent and stationary/MMI status with regards to both shoulders and both knees.

RE: [redacted]
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: [redacted]

AMA IMPAIRMENT:

Using the AMA Guides, Fifth Edition:

For the bilateral shoulders he is given impairment due to the lack of motion in abduction using figure 16-43. The shoulders are given 5% upper extremity impairment for each side, which using Table 16-3 gives him 3% whole person for each side - totaling 6% for the shoulders.

Similarly, the knees show degenerative joint changes, meniscal changes, and traumatic synovitis that limit his ambulatory capacity, repetitive heavy weight lifting, and squatting, pushing, and pulling-type maneuvers. Going up and down stairs would be difficult for him. Taking all of this into consideration, he is given rated using Table 17-33 similar to a partial medial and lateral meniscectomy, with a 4% WPI for each knee, totaling 8%.

His total whole person impairment is 14%.

FUTURE MEDICAL CARE:

For a flare-up and allowance for future care is indicated. This would be brief physical therapy, and the use of anti-inflammatory medication, and possibly arthroscopic debridement of both knees and shoulders. However, I would only do arthroscopic surgery if he has a significant amount of pain and limitation of range of motion and function.

At the present time, the patient is not willing to have any type of surgical intervention. I do not believe surgery is necessary at this time as he is able to function adequately.

CAUSATION:

A detailed history obtained from the patient indicated that he worked as a carpenter and had to carry heavy weights, do repetitive squatting, and use of both upper extremities with power saws, grinders, etc. His complaints are noted in the records from [redacted] in starting in [redacted] There is no question that this patient has definite evidence of constant repetitive type of injuries to his shoulders and knees. I do feel he reasonably sustained injuries on a cumulative trauma basis with [redacted] and [redacted]

I will not comment on his hearing loss, as this is beyond the scope of my practice.

However, this should be evaluated by an ENT or audiologist to determine this cause and any impairment.

APPORTIONMENT:

Although he has fairly degenerative changed in the knees and shoulders, this appears to be attributable to his work at [redacted] and [redacted] on a CT basis. In the absence of records that indicate any injuries with another employer, I would apportion his disability 100% to his work a[redacted]h and [redacted] during the CT period.

DISCLOSURE:

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

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

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

Yours sincerely,

[redacted]

DIVAKAR KRISHNAREDDY, M.D.
Diplomate, American Board of Orthopedic Surgery

Signed in Los Angeles County on this date [redacted]

[redacted]

December 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: January 4, 2023, Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
RICHARD C. ROSENBERG, M.D. - ORTHOPEDIC

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Richard Rosenberg, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

Richard Rosenberg, M.D., is Board Certified in Orthopedic Surgery. He received his medical degree from the University of Texas in 1977 and completed his residency at the University of California, Irvine in 1981. Dr. Rosenberg has 35 years of experience as an independent medical examiner performing medical legal evaluations for both public and private organizations.

Upon approval to the panel, LACERA will conduct a virtual orientation with DRS staff, legal counsel and the physician and his management team to provide a comprehensive overview of the LACERA Panel Physician Guidelines, requirements, and protocols to ensure a thorough understanding of the Rules in Evaluating Applicants, Disability Retirement Law Standards, and what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff will also cover report submission timeframes, fee schedule and billing procedures. Additional diagnostic testing request protocols; medical license, Board Certification, and insurance coverage requirements. Lastly, staff will provide an overview of the Quality Control Questionnaire process and procedures.

On December 21, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Richard Rosenberg, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Richard C. Rosenberg, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

/TLC

LACERA Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-6132 • 800/786-6464

APPLICATION TO LACERA PANEL OF EXAMINATION PHYSICIANS

ALL APPLICANTS MUST SUBMIT THE FOLLOWING WITH THEIR APPLICATION

- Current Curriculum Vitae
- Two (2) Sample" Medical Reports – Must be Redacted
- Copy of Medical License
- Copy of Board Certification(s) – Applicant must be board certified to qualify for panel
- Certificate of Insurance

GENERAL INFORMATION Please attach a list of any additional locations.	Date 3/7/2022
Physician Name: Richard C Rosenberg, M.D.	Group Name: Click or tap here to enter text.
Primary Address: 18370 Burbank Blvd., Ste 614 Tarzana CA 91356	
Primary Contact: Gabriela Bonsell	Title: Office Manager
Telephone: 818-996-6800 Fax: 818-996-2929	Email: gabriela@tarzanaortho.com
Secondary Address: Click or tap here to enter text.	
Telephone: Click or tap here to enter text. Fax: Click or tap here to enter text.	Email: Click or tap here to enter text.

PHYSICIAN BACKGROUND	
Field of Specialty: Orthopedic Surgeon Board Certification ☒Yes ☐No	Subspecialty: Click or tap here to enter text. Board Certification ☐Yes ☐ No
License # **G34887** Expiration Date: **01-31-2024**	
Has your license been suspended in the last 3 years? ☐Yes ☒No Has there been any disciplinary actions filed against you in the last 3 year?☐Yes☒ No	

EXPERIENCE AND CURRENT PRACTICE
Indicate the number of years of experience that you have in each category and the time spent performing each activity.

Type	Number of Years
AME	25
IME	35
QME	35
Workers' Compensation Evaluations	35
Disability Evaluations	35
Med-Legal Reports	35

Current Practice	Time Spent (%)
Treatment	40
Evaluations	55
Research	5
Teaching	
	100 %

Performing Medical Evaluations for Public Organizations ☒Yes ☐No	
Performing Medical Evaluations for Private Organizations ☒Yes ☐No	
Please Names of Organizations: Ventura County and City of Los Angeles	
Estimated Time from Appointment to Examination: ☐2 weeks ☒3-4 Weeks ☐Over a month	Able to Submit a Final Report and Invoice in 30 days: ☒Yes ☐No

LACERA FEE SCHEDULE	
Physical Exam and Initial Report	$2,015.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Record Review Only and Initial Report	$1,007.50 + Additional Fee for Reviewed Records* (see Review of Record rate)
Psychiatric/Psychological Examination (in office) and Initial Report*	$ 4, 030.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Psychiatric/Psychological Examination (no exam) and Initial Report*	$ 2,015.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Toxicology and Oncology Examination (in office) and Initial Report*	$ 3,022.50 + Additional Fee for Reviewed Records* (see Review of Record rate)
Toxicology and Oncology Examination (no exam) and Initial Report*	$ 1,511.25 + Additional Fee for Reviewed Records* (see Review of Record rate)
*Review of Records (by Physician)	$ 455.00 per inch (LACERA will pay up to 1 hour of record-review per inch of medical records)
*Review of Records (by Nurse)	$ 75.00 per inch (LACERA will pay up to 1 hour of record-review per inch of medical records)
Supplemental Report	$ 455.00 per hour
Supplemental Report when Panel Physician Guidelines were not followed	No charge
Other Fees	
Administrative Hearing Preparation	$ 455.00 per hour
Depositions	$ 455.00 per hour with 2 hours minimum
Expert Witness in Superior or Appellate Court	$3,500 – Half Day
Expert Witness in Superior or Appellate Court	$7,000 – Full Day
Cancellation Policy and Fees Please indicate your cancellation policy and any applicable fees.	
What is you Cancellation Policy? (Attach policy, if applicable). Appointments need to be cancelled within 6 days of appointment	
Cancelled Exams that do not adhere to your stated policy:	Fee: $**$500**
Cancelled Hearings that do not adhere to your stated policy:	Fee: $**$500**

Name of person completing this form:

Print Name: Gabriela Bonsell	Title: Office Manager
Physician Signature:	Date 03/07/2022

You may attach additional pages if necessary.

Revised:12/8/21

Orthopedic Surgery

RICHARD C. ROSENBERG, M.D.

Diplomate American Board of Orthopedic Surgery

CONTACT INFORMATION	**818.996.6800** drrosenberg@tarzanaortho.com www.drrichardrosenberg.com
PRACTICE FOCUS	Fractures ▪ Joint Injuries & Arthritis ▪ Neck & Back Injuries Foot & Hand Injuries
COLLEGE	University of California at Berkeley, Berkeley, CA Bachelor of Sciences
MEDICAL SCHOOL	University of Texas Medical Branch at Galveston, Galveston, TX M.D. 1976
INTERNSHIP	University of California at Irvine, Irvine, CA General Surgery 1976 - 1977
RESIDENCY	University of California at Irvine, Irvine, CA Orthopedic Surgery 1977 - 1981
PROFESSIONAL SOCIETIES & BOARD CERTIFICATION	Diplomate of American Board of Orthopedic Surgery Fellow American Academy of Orthopedic Surgeons California Orthopedic Association Western Orthopedic Association
PRIOR TEACHING APPOINTMENTS	VA Medical Center, North Hills, CA Clinical Instructor through 1994 Northridge Hospital Medical Center, Northridge, CA Clinical Instructor - Residency Program through 2005
HOSPITAL PRIVILEGES	Providence Tarzana Medical Center, Tarzana, CA Sherman Oaks Hospital, Sherman Oaks, CA St John's Hospital, Oxnard, CA
EVALUATIONS	IME, QME, AME, Expert Testimony

[redacted]

ADDRESS

RE: Jane Doe
EMP: County of *****
PT FILE #: *****
D/E: [redacted]
CASE #: *********

Dear M*. *****:

The above-captioned patient is a [redacted] year-old, right-handed female who was seen in my office on [redacted] for an orthopedic evaluation of injuries which she associates with accidents and activities that occurred at work.

EMPLOYMENT HISTORY:

She began her employment with the County of ***** on [redacted] as a Health Technician III.

She worked in a locked mental health facility. Her job duties included checking on patients every 15-30 minutes each morning, giving patients a shower and distributing meals and snacks. She admitted new patients, which including taking a history and assessing them. She collaborated with social workers to meet their needs. She took vital signs. Utilizing a van, she took patients to meetings, to other facilities, to hospital emergency rooms and to doctors' appointments. She took them to get lab work and to medical diagnostic testing facilities. She picked up prescriptions. Some of the patients had an impounded vehicle. She took them to the bank and then to get their vehicles but if their vehicles were not yet available, she made arrangements for them to stay in a hotel. Someone in the facility would have to be with each client at all times, regardless of where they were. Some were combative/assaultive and she had to restrain them. Sometimes she had to quickly administer medication to them to calm them down. She assisted hospital nurses to restrain patients. She translated for physicians. She ordered supplies

and snacks and stocked them when she returned. She entered information about every activity of each patient every day. She spent approximately two to four hours a day typing. She spent about one to two hours a day writing each day.

The physical requirements consisted prolonged sitting, prolonged sitting while driving, prolonged standing and prolonged walking. She did repetitive bending at the knees and waist and twisting and turning at the waist. She did stooping, squatting and kneeling. She climbed stairs. She did prolonged neck flexion. She pushed and pulled heavy carts. She did overhead reaching and repetitive arm and hand movement, including reaching, and simple and forceful grasping. She lifted and carried over 50 pounds, but the actual weight is unknown. She worked 12 hours per day, 3 days per week. She did worked frequent overtime.

She last worked for this employer on [redacted]. On that day, she was placed on modified duty which her employer could not accommodate.

She is now medically retired.

SUBSEQUENT EMPLOYMENT:

She denies subsequent employment.

HISTORY OF INJURY:

Ms. Doe states that she attributes her current neck and right shoulder pain to an incident that occurred at work on [redacted]. She was translating for a patient when she was attacked and pulled down to the ground. She experienced pain in neck and right shoulder.

She went to a hospital emergency room. She recalls being off work for a period of time.

She believes she saw Dr. ***** *****. She had an MRI of her cervical spine and possibly her right shoulder. She had physical therapy with no improvement in her symptoms. She underwent several cervical spine epidural injections and cortisone injections into her right shoulder but the results were temporary. She was unable to lift her neck while lying down and was recommended to undergo surgery.

She underwent cervical spine surgery sometime between [redacted], performed by Dr. *****, followed by post-operative physical therapy. She experienced decreased pain

in her neck, but as time went on, the pain increased. She does not recall how long she was off work. At one point in time, an ergonomic evaluation of her work station was completed. She states that most of the recommendations for the changes were not implemented.

She does not remember when the pain in her right wrist and hand, numbness and tingling in her right arm and right middle trigger finger began. She attributed it to continually opening heavy doors. She states that all of the doors, with the exception of the community room, were heavy. She also attributed to taking down patients, picking up and moving heavy charts and picking up and moving heavy boxes.

Her primary care physician, Dr. *****, placed on modified duty. She had many restrictions, including no patient contact. Her employer was unable to accommodate her. She was off work for nearly a year. During this time, her employer tried to find a position for her.

In [redacted], she became an Office Assistant III. Prior to this, at some point in time, she began seeing Dr. ***** for her right wrist and Dr. ***** for her neck and right shoulder. At some point in time, Dr. ***** referred her to Dr. ***** for her right shoulder. She does not remember if she began this job with restrictions at this time. She was moved to various departments. She worked in the x-ray/ultrasound department in the alcohol/drug program, maintenance department. She worked in the financial/administration building as a biller. All of her symptoms increased during this time due to repetitive movement.

Dr. ***** became her primary care physician for her work injuries. He referred for physical therapy for her neck. The therapists worked on her right shoulder as well. She did not have any improvement. She was administered injections in his office. She had relief for about a month each time, then the pain returned to the same level as before. She underwent an MRI study and believes she was told the screws in her neck had shifted.

For her right shoulder, Dr. ***** referred her to physical therapy. She did not have any improvement in her condition. Following a MRI of her shoulder, she was told she needed to undergo surgery. She believes she had a tear. The request was denied.

It was about three years later that she began seeing Dr. ***** for her right shoulder and right middle trigger finger. She only experienced temporary improvement in the level of her pain. A request was made for surgery. By the time the request was authorized, Dr. ***** had passed away. She was referred to Dr. ***** for her right shoulder. She selected to treat with Dr. ***** for her right trigger finger.

Dr. ***** agreed that right shoulder surgery was necessary. Surgery was eventually authorized.

Dr. ***** referred her for physical therapy for her right wrist and hand. She did not feel that this was helpful. She underwent electrodiagnostic testing of her upper extremities and she was diagnosed with carpal tunnel syndrome.

She subsequently has undergone two carpal tunnel surgeries, the first done by Dr. ***** for the left carpal tunnel syndrome and the second done by Dr. ***** for the right carpal tunnel syndrome.

Dr. ***** and ***** gave her a work restriction of no working more than two hours a day. After a week, she was unable to continue because she was unable to sit for two hours and because she was unable to use her right hand to perform duties.

Ms. Doe underwent cervical spine surgery in [redacted] in [redacted]. She is not sure if Dr. ***** did the surgery or if another surgeon performed it. She had postoperative physical therapy. She was unable to return to work because her restrictions could not be accommodated.

She underwent right shoulder surgery, performed by Dr. *****, around [redacted]. She completed a course of postoperative physical therapy. She experienced decreased pain and a better range of motion.

She believes it was in [redacted] that Dr. ***** performed a right middle trigger release. She completed a course of postoperative physical therapy. She no longer has any triggering in this finger.

Ms. Doe does not recall seeing any other physicians or undergoing any other diagnostic testing or treatment.

She does exercises her right shoulder with a band infrequently. She does range of motion exercises for her neck nearly every day. She uses ice on her neck and right shoulder, as needed. She does not wear any supports or braces. She has also undergone left middle finger surgery to correct a trigger finger problem.

PRE-POST CAPACITY FOR LIFTING:

She states that prior to this injury she was able to comfortably lift and carry approximately 60 pounds with both hands. Presently, she is able to comfortably lift and carry approximately 20 pounds.

PAST MEDICAL HISTORY:

She denies heart disease, diabetes, lung disease, cancer, arthritis, fibromyalgia, osteoporosis or blood disorders. She has hypertension.

In 1981 she was involved in a motor vehicle accident. She injured her knee. She has undergone three surgical procedures on the left knee. The final surgical procedure was a total knee arthroplasty in approximately [redacted]

Ms. Doe states that she was involved in many altercations and involved in many accidents while working for the County of *****. She injured various parts of her body and received treatment and the injuries resolved.

Around [redacted], her sister hit her right shoulder with a pipe. She received treatment. She does not remember having any problems with her shoulder following the treatment she received.

In [redacted], the right side of her face drooped. She went to a hospital emergency room. She was admitted. She underwent an MRI study of her brain. After reviewing the results, she was told that stress was the cause of her problem. Her symptoms resolved after a few months.

In [redacted], she suffered a stroke. She was told she had scar tissue from what had happened in [redacted]. She was in the hospital for a week.

She denies any other prior or subsequent work, auto or sports-related accidents or injuries.

SOCIAL / RECREATIONAL HISTORY:

Ms. Doe is single and has adult children.

She takes short showers. If she takes a longer shower and takes her time washing her hair, her arms get tired.

She now sits down to put on her underwear, pants, socks and shoes. She states that she puts on her other clothing quickly so it is not a problem.

She has difficulty reaching while performing household chores. She works slower than usual and takes frequent breaks. She no longer does laundry or grocery shopping.

She does not do any writing or typing because she avoids sitting. Prolonged sitting aggravates her neck. She talks into her phone to send text messages. For prolonged phone calls, she uses the speaker on her phone. She has difficulty opening jars, bottles and cans. She denies trouble turning doorknobs. She denies dropping things.

She does not drive because of her stroke. She denies difficulty getting in and out of vehicles.

Pain in her neck and right shoulder wakes her up on occasion. Numbness does not wake her up. She gets about six hours of sleep at night. She sometimes dozes off but states she does not take naps.

She denies internal complaints.

Intimate relations are not an issue at this time.

She states that she able to manage the stress she feels as a result of her physical condition and the inability to function as before but she is frustrated.

EXTRACURRICULAR ACTIVITIES:

Ms. Doe no longer goes to the park, rides her bicycle or play outside with her grandson. She no longer plays softball. Prior to her work injuries she was on a team, playing softball weekly.

ALLERGIES & MEDICATIONS:

Ms. Doe is allergic to sulfa drugs.

At the present time she is taking:

1. Clopidogrel 75 mg., one per day.

2. Nortriptyline 10 mg., two at night.
3. Medication for hypertension, 5 mg., one per day.
4. Tylenol 650 mg., two as needed.

PRESENT COMPLAINTS:

NECK: Currently, Ms. Doe complains of frequent pain in her neck. She rates her pain as an average of 4 on a scale of 1-10. She does not have headaches. The pain radiates into her right shoulder. She experiences intermittent numbness and tingling in her right arm. She does not notice cracking or popping in her neck with turning of her head. She points to the base of the neck on the left side when describing the pain.

RIGHT SHOULDER: Currently, Ms. Doe complains of frequent pain in her right shoulder. She rates her right shoulder pain as an average of 6 on a scale of 1-10. The pain radiates into her right shoulder blade. She does not notice cracking or popping in her shoulders with movement of her arms.

BILATERAL WRISTS / HANDS: Currently, Ms. Doe complains of infrequent pain in her right wrist and hand. She does not have pain in her thumb or fingers. She rates her wrist and hand pain as an average of 3 on a scale of 1-10. The pain does not radiate. She does notice swelling. She notes intermittent weakness in her right hand.

PHYSICAL EXAMINATION:

Height: [redacted]" Weight: [redacted] pounds
Blood Pressure: 147/88

She is an alert, talkative individual who appears to be her stated age. She is not using any walking aids or braces. She has a normal gait. It was noted that she has a well-healed total knee arthroplasty incision.

Examination of the cervical spine shows that there is an anterior cervical discectomy incision on the left side at approximately the C6 level. There is no tenderness over this healed incision. There is no tenderness or spasm over the sternocleidomastoid muscles bilaterally. Flexion is 30°, extension is 55°, left and right bending are 20° and left and right turning are 45°. There is a negative foraminal compression test and a negative Spurling's sign. There is tenderness over the left trapezius muscle with some muscle spasm.

Comprehensive motor examination of the upper extremities including the shoulder abductors, flexors and extensors, the wrist flexors and extensors, the forearm supinators and pronators, the finger extensors, flexors and intrinsic muscles shows 5+/5+ motor power bilaterally.

Reflexes	Right	Left
Biceps tendon reflex	2+	2+
Triceps tendon reflex	2+	2+
Brachioradialis reflex	2+	2+

Comprehensive sensory examination of the upper extremities shows a normal dermatomal pattern to pinprick and deep touch.

Examination of the right shoulder shows multiple healed arthroscopic incisions. Abduction forward flexion was limited to approximately 140° compared to 165° on the left. Internal rotation takes the right hand to L4 and takes the left hand to L2. There is diffuse right deltoid tenderness. There is a negative Neer and negative Hawkins impingement sign. There is a negative O'Brien's test. There is no subacromial crepitus.

Examination of the wrists and hands shows a well-healed carpal tunnel incision on the right wrist. There is a barely perceptible endoscopic type healed incision of the left wrist. There is a negative Tinel's sign bilaterally over the carpal tunnel and a negative Tinel's

sign over Guyon's canal. There are negative Phalen's tests bilaterally. There is no triggering of the fingers. There is full range of motion of the fingers. There is a negative Finkelstein's test bilaterally. Sensation is normal in the distribution of the radial, ulnar and median nerves. There is no intrinsic muscle atrophy bilaterally.

Upper extremity measurements:
Major Hand: Right

Circumferences:	Right	Left
Biceps at greatest circumference	25 cm	26 cm
Elbow	22 cm	22 cm
Forearm (2" below elbow)	22 cm	22 cm
Wrist	15 cm	15 cm
Hand	21 cm	21 cm

Grip strength: Jamar Dynamometer Readings

Right	Left
18 kg	16 kg
12 "	20 "
11 "	19 "

X-RAYS:

CERVICAL SPINE: There has been a C4-5 anterior fusion with a cage and a plate with screws in the body of C4 and C5. There is straightening of cervical lordosis. The oblique views do not show any narrowing of the neural foramen. AP view shows the plate and the midline anteriorly. Open mouth view shows a normal odontoid.

RIGHT SHOULDER: AP view shows that there has been a Mumford procedure with an oblique osteotomy of the distal clavicle. The glenohumeral joint appears intact. The scapular Y view shows a type I acromion.

BILATERAL WRISTS / HANDS: AP view is normal. Oblique views are normal. Lateral view bilaterally is normal.

REVIEW OF RECORDS:

The following is a review of medical records on the above-captioned patient:

There is an Employee's Claim for Workers' Compensation Benefits form dated [redacted] noting injury on [redacted] to brain, left sided temporary paralysis.

There is an Application for Adjudication of Claim dated [redacted] noting injury on [redacted] to wrist/hand described as patient developed carpal tunnel syndrome due to excessive use of hand and wrists.

There is a Report of Electrodiagnostic Evaluation from ***** *****, M.D. dated [redacted]. Nerve conduction study was performed of bilateral upper extremities, including the radial nerve and EMG was performed, limited to the ulnar territory bilaterally and shoulder girdle muscles. The patient was unable to tolerate further study. She is status post neck fusion C6-7 in [redacted].

Impression:

1. Prolonged right median distal motor latency and sensory latency and transcarpal conduction time.
2. The remainder of the nerve conduction studies is normal. The left median distal motor latency and mid-palmar latency is borderline, however – borderline findings for carpal tunnel syndrome.
3. Changes of denervation and reinnervation in the ulnar territory as well as in the upper cervical myotomes bilaterally.

Comment: In an appropriate clinical context this study would support a clinical diagnosis of right carpal tunnel syndrome and bilateral cubital tunnel syndrome. I am unable to find a Tinel's sign at either elbow, however. Care should be exercised in interpreting the above abnormalities in the upper cervical myotomes, as the patient is postoperative.

There is a Report of X-rays of the left hand from ***** ***** ***** ***** Imaging Center dated [redacted]. Ordered by Dr. *****.

Impression: Two views radiographic examination of the left hand is within normal limits.

X-rays of the cervical spine were also performed.

Impression:

1. Status post anterior cervical discectomy and fusion procedure at C5-6 and C6-7.
2. Degenerative spondylosis at C4-5.

X-rays of the right hand were also performed.

Impression:

Tiny spurring consistent with slight degenerative changes regional to distal interphalangeal joints of the right middle and little fingers.

There is an Agreed Medical Examiner's Report from **********, M.D. The patient was seen on [redacted]. She was injured on [redacted] and on a continual trauma basis. She is a 51-year-old woman employed first as a mental health technician and more recently as an office assistant III with County of ***** for a total of eighteen years. She worked as a health technician from [redacted] and she was then given the position of office assistant on [redacted]. The patient stated in her deposition that she concurrently worked for ***** ***** (Telecare) for over a year and for ***** ***** ***** over a year, but she sustained no injuries while working there.

Dr. ***** noted the records show she was involved in an automobile accident in [redacted] sustaining injuries to her left knee. She also reported a prior left wrist injury in [redacted] and she received some type of settlement for that injury. She underwent a diagnostic arthroscopy with debridement of the anterior horn tear of medial meniscus with Dr. ***** ***** on [redacted].

Dr. ***** noted the records show that while transferring a client from a bed to a gurney on [redacted] she pulled the lower left side of her back. She saw Dr. ***** ***** and was diagnosed with a lumbosacral strain. Her low back pain had resolved and she was felt to be able to work without restrictions.

Dr. ***** noted the records show she was seen on [redacted] by Dr. ***** for left thoracic muscle spasm after showering in the morning when she dropped to the floor and was unable to lift her head.

Dr. ***** noted the records also show she punctured the left index finger at work on [redacted] She had possible exposure to urine and was seen in Employee Health Services.

Dr. ***** indicated the records also noted she hyperextended her right middle finger while playing softball on [redacted]. X-rays of the right hand revealed a posterior subluxation of the distal phalanx of the third digit and an associated tiny chip fracture along the volar based of the distal phalanx. She underwent a reduction of the finger dislocation and a splint to the right third digit was applied.

Dr. ***** noted the records indicated she was struck several times with a copper pipe by her sister on the neck and right shoulder on [redacted]. She saw Dr. ***** and was diagnosed with neck and right shoulder contusion. She underwent x-rays of the cervical spine which allegedly showed osteoarthritis.

The records showed while restraining a patient on [redacted], she pulled her left shoulder muscle. She saw Dr. ***** and was diagnosed with biceps tendonitis. She also complained of swelling of her feet and hands to Dr. ***** on [redacted] and was felt to have glucose intolerance, water retention and constipation. The records show she saw Dr. ***** on [redacted] and complained of back problems and three days of muscle spasm in the left shoulder, possibly due to gardening. She was felt to have a strain. She then saw Dr. ***** on [redacted], who diagnosed her with sinusitis and spasm of her back and left trapezius. She awoke with pain in her left shoulder on [redacted] and saw Dr. ***** and was diagnosed with tendonitis.

The records show the patient developed left knee pain and swelling in [redacted] and saw Dr. ***** who recommended further care. She then saw Dr. ***** on [redacted] who diagnosed her with left knee abrasion with a slight contusion and noticed a slight patch of erythema on the anterior left knee and a well-healed scar. X-rays of the left knee revealed osteoarthritis of the left knee. She was seen in follow-up at ***** County Medical Center for her left knee and left shoulder/trapezius muscle pain and was treated with medications.

The records show the patient saw Dr. ***** on [redacted] and stated her boyfriend beat her twice. She complained of left knee pain and was given Bextra. She was also seen at Employee Assistance Program in [redacted] regarding anxiety and a lot of stress at work. She cut the base of her nail off her left thumb while moving a stove in [redacted] and saw Dr. ***** who applied a band-aid and a thumb splint. She was also treated with a soft collar for her neck at ***** County Medical Center.

The records show while she was unloading supplies after pulling a cart across the way to the facility on [redacted], she developed muscle cramps in the left shoulder, as well as pain radiating to the second and fourth fingers with tingling. She saw Dr. ***** ***** and was diagnosed with left trapezius spasm and prescribed Ibuprofen and Flexeril. She attended a course of physical therapy for the left shoulder and continued working with restrictions. She was seen at ***** County Medical Center emergency room on [redacted] with left-sided neck and arm spasms and was diagnosed with a pinched nerve and cervical scapular pain with radiation down the left arm and was given Vicodin and Diazepam.

The records show she continued to be symptomatic and underwent electrodiagnostic studies of the upper extremities, results unknown. She underwent MRI of the cervical spine on [redacted], which allegedly showed a probable thyroglossal duct cyst, described as a loculated cystic fluid collection in the midline at the base of the tongue, there appeared to be a small fluid tract extending down to the region of the thyroid, loss of the normal cervical lordosis, mild to moderate right foraminal stenosis at C5-6 due to uncinate spurring and possible 3 mm left lateral disc protrusion in the proximal nerve root canal at C6-7. Nerve tests were repeated by Dr. ***** on [redacted], allegedly suggesting left C7 root irritation.

Dr. ***** indicated the patient states she was grabbed by the hair by a patient and pushed down to the floor sometime in [redacted] and she sustained injuries to the left side of her neck. She was seen at ***** County Medical Center emergency room. She was treated by Dr. ***** ***** with a course of physical therapy for six months, which was beneficial. Those records were not provided for my review and all details are unknown.

Dr. ***** indicated the records show the patient was then seen by Dr. ***** in [redacted] for anxiety symptoms from verbal abuse by her supervisor and she was prescribed Paxil. She was also diagnosed with diabetes mellitus II in [redacted]. While helping to lift a patient and move her onto a gurney in late [redacted], she noticed pain in her right forearm. She saw Dr. ***** ***** on [redacted] and was felt to have right forearm tendonitis. She was given a splint and ice. She was seen in follow-up at ***** County Medical Center for her left knee and was given work restrictions of no repetitive bending at the knees and no repetitive sitting or standing.

Dr. ***** noted while restraining a patient on [redacted] the patient grabbed her hair and pulled her head down. She noticed severe pain and was seen by Dr. ***** ***** on [redacted] and was felt to have cervical strain and scalp contusion. The patient was

also seen by Dr. ***** ***** her private psychologist on [redacted] and was treated extensively. She underwent x-rays of the cervical spine on [redacted] which revealed degenerative changes most prominent at C5-6. She was seen by Dr. ********** for persistent neck complaints on [redacted] and was diagnosed with cervical strain and history of cervical spondylosis at C5-6 and C6-7. MRI of the cervical spine and physical therapy was recommended. She was given work restrictions. She attempted to return to work the next day but had stabbing right-sided neck pain and was placed on temporary total disability.

An MRI of the cervical spine was performed on [redacted] allegedly revealing a 1 mm central annular bulge at C4-5 and osseous hypertrophic changes bilaterally at C5-6 and C6-7 with mild encroachment on the foramina. Dr. ***** extended her disability and started her on Medrol Dosepak. She was rated permanent and stationary by Dr. ***** on [redacted] and she was given a whole person impairment of the cervical spine of 0%. Future medical care was recommended to include anti-inflammatory or non-narcotic analgesic medications. No additional physical therapy, cervical epidural steroid injections, chiropractic care, acupuncture or surgery was recommended.

Dr. ***** indicated she continued seeing Dr. ***** for her anxiety and stress complaints and was noted to be in an abusive relationship. She was suspected to have a bipolar disorder. The records show she developed increased symptoms in her left knee and was evaluated by Dr. ***** ***** at ***** County Medical Center on [redacted]. She was diagnosed with left knee degenerative disease and Supartz injections were discussed, as well as possible surgery

Dr. ***** indicated on [redacted], she was referred to Dr. ***** *****, an AME and complained of pain in her right neck, radiating down the right upper extremity to the right thumb, index and middle fingers of the right hand with numbness. She was felt to have cervical discogenic disease and was rated permanent and stationary. According to Dr. ***** she received three injections to the cervical spine without significant relief. Dr. ***** felt she was a qualified injured worker and in need of a vocational rehabilitation program. She was given a whole person impairment rating of 8%. Future care for the cervical spine was indicated including pain medications and physical therapy. He apportioned 10% to non-industrial, 10% to her [redacted] specific injury and 80% to the [redacted] injury.

Dr. ***** noted the records show she underwent a series of three Supartz injections in [redacted], which allegedly did not help. She then underwent an anterior cervical discectomy and fusion at C5-6 and C6-7 in [redacted]. A copy of

the operative report was not provided for my review. She underwent postoperative physical therapy which only helped a little.

Dr. ***** noted according to Dr. *****, the patient noticed increasing pain in her right shoulder after her cervical spine fusion. He administered subacromial injection to the right shoulder on [redacted]. She was sent for a course of physical therapy. On [redacted], she was also diagnosed with right tendonitis and impingement syndrome.

Dr. ***** noted the records indicate the patient saw Dr. ***** in follow-up on [redacted], [redacted] for the left knee and x-rays revealed severe osteoarthritis of the knee with a small joint space effusion. She was prescribed therapy for the left knee Dr. ***** felt surgery was appropriate. She went back to modified duties in [redacted]. She failed to improve and Dr. ***** performed a left knee arthroscopic lysis of lesions with manipulation under anesthesia on [redacted] apparently on a private basis.

She was taken off work and was given a dyna splint to the left knee and was sent for a course of physical therapy. On [redacted], she was examined by Dr. ***** ***** and Dr. ***** ***** for her psychiatric disorders and she was given a GAF of 73, equating to a whole person impairment of zero. Future psychiatric care was recommended on a non-industrial basis and she was felt to have reached maximal medical improvement in [redacted].

Dr. ***** noted Dr. ***** ***** at ***** County Medical Center took over the left knee care in [redacted] and prescribed more medications, including Vicodin and Ibuprofen. X-rays of the left knee revealed total left knee prosthesis in place without evidence of dislocation, loosening or acute fracture. The patient states she continued working and in early [redacted] she developed pain, numbness, tingling, swelling, stiffness, weakness and spasms in both hands, left greater than right, as well as locking of the left middle finger. Dr. ***** also saw her for a pus pocket over the medial and proximal nail border of the left first toe on [redacted]. He diagnosed her with paronychia of the left first toe and removed the pus pocket. The patient complained to Dr. ***** of being unable to sleep and back and neck spasms in [redacted] and she was treated with medications.

Dr. ***** indicated the records show the patient developed tingling in her left cheek and left hand and transient left leg weakness and she saw Dr. ***** ***** on [redacted] [redacted] at ***** County Medical Center. She was diagnosed with an acute left facial, left hand tingling probably secondary to a lacunar infarct in the thalmic region, or possible stress responses with somatic manifestation from severe anxiety, severe distress

secondary to altercations at work, elevated blood pressure of unclear significance, history of osteoarthritis and cervical radiculopathy and status post discectomy and cervical spine fusion. She underwent CT scan of the brain, a carotid duplex evaluation and an electrocardiogram, which were within normal limits. An MRI of the brain revealed a 4x5 mm focal area of abnormal signal seen within the right putamen possibly a sequela of chronic small vessel ischemic change.

Dr. ***** noted she underwent a three phase bone scan on [redacted] revealing asymmetric accumulation of radioisotope in the left knee surrounding the prosthesis on all three phase of the bone scan concerning for acute process, activity was seen on the delayed bone images of both the femoral and tibial components of the prosthesis, probably representing loosening of the prosthesis given the activity in all three phases, and peripheral increase in uptake in the mid to lower thoracic spine most likely representing facet degenerative arthropathy given the distribution.

Dr. ***** noted she underwent a right upper extremity venous duplex evaluation on [redacted], which was completely normal. She complained to Dr. ***** of pain in the right trapezius muscle, radiating down to her right hand and right middle finger on [redacted]. She also saw Dr. ***** ***** in [redacted] who diagnosed her with a bipolar disorder, mood swings and panic attacks and felt the patient was totally disabled.

Dr. ***** noted the patient continued to have problems with her left knee and on [redacted] she underwent revision modular left total knee replacement, subtotal synovectomy, complex plastic closure and extensor mechanism lengthening, performed by Dr. ***** ***** at ***** Medical Center. She continued treating with Dr. ***** ***** for her right shoulder and neck and she also complained of numbness in both hands in [redacted] Her disability was extended. She was also examined for gynecological complaints.

Dr. ***** noted an MRI of the cervical spine was repeated on [redacted] revealing status post anterior fusion of the C5 through C7 vertebral levels, postsurgical changes and ferromagnetic artifact precluding optimal evaluation of the anterior spinal canal at the level of the fusion, mild degenerative disc disease of the C4-5 disc, no definite central spinal canal or neural foraminal stenosis and no evidence of acute fractures or subluxations.

Dr. ***** noted Dr. ***** continued seeing her for the right upper extremity and additionally diagnosed her with a right carpal tunnel syndrome. She was seen by Dr.

***** ***** on [redacted] and a right carpal tunnel release was recommended. Dr. ***** felt she was disabled at the time and prescribed more medications, including Neurontin.

Dr. ***** noted on [redacted], she was seen by *. *. ***** and was felt to have right carpal tunnel syndrome and possible internal derangement at the level of the right wrist. Dr. ***** felt her clinical picture was compatible with a double crush syndrome and recommended open surgery in the form of release of carpal tunnel on the right wrist and a course of occupational therapy and physical therapy. She was again seen by Dr. ***** on [redacted] and was diagnosed with bilateral carpal tunnel syndrome and evaluation with a hand surgeon was recommended. She continued treating with Dr. ***** ***** for other medical complaints, including her neck and left knee. According to Dr. *****, the patient fell forward onto her left knee on [redacted] and she developed increasing pain. He diagnosed her with a sprain/contusion of the left knee and plantar fasciitis.

Dr. ***** noted the patient states she continues treating with Dr. ***** on a conservative basis and surgery is currently pending. She states she returned to modified work on [redacted]. She continues to have many problems related to both upper extremities.

Dr. ***** indicated her chief complaints include the following:

1. Pain, both hands and wrists.
2. Numbness, both hands and wrists.
3. Tingling, both hands and wrists.
4. Stiffness, both hands, left greater than right.
5. Decreased strength, both hands.
6. Swelling, both hands and wrists.
7. Night pain, both hands and wrists.
8. Dropping of items, both hands.

Physical examination revealed she was a well-developed and nourished, slightly nervous and overweight woman appearing to be in good general health. Pertinent findings are restricted to the neck and upper extremities. The dominant arm is the right one. The patient has bilateral injuries. Neck: She holds her head in a normal manner. There was a well healed anterior neck scar. There was no evidence of scoliosis or kyphosis, but a mild loss of the normal cervical lordotic curve. Active range of motion including flexion and extension were normal, but lateral bending and rotation were decreased. There was no

tenderness in the trapezius, levator and rhomboid muscle groups. There was no spasm and there were no trigger points. The cervical compression test (Spurling test) and distraction tests were normal. There was no pain on extremes of motion. There was no significant cervical adenopathy. The trachea was midline and the carotids were strong bilaterally and there was a well-healed anterior neck scar. Range of motion of the cervical spine was flexion 50 degrees, extension 60 degrees, right and left lateral bending 35 degrees and right and left rotation 60 degrees.

Examination of the shoulders revealed there was full range of motion and good strength. There was crepitus and clicking of the left shoulder. There was no tenderness in the glenohumeral joint, the acromioclavicular joint, rotator cuff or subdeltoid bursa. There was no evidence of instability nor of impingement (rotator cuff disease). The straight arm, drop arm and impingement tests were normal. Range of motion was normal bilaterally. Apley scratch test, Arc of rotation, Neer, Hawkins, drop arm, Yergason's, speed, apprehension, O'Brien and straight arm raising tests were all negative bilaterally.

Examination of the elbows revealed normal appearance. There was no evidence of swelling or edema. There was no olecranon, medial epicondylar or lateral epicondylar tenderness. There was no instability nor a varus or valgus deformity. Motion including flexion and extension were normal. Strength was good. Active range of motion was normal bilaterally.

Examination of the forearms revealed pronation and supination were normal. There was no tenderness of any of the muscle groups. There was no evidence of muscle atrophy. Circumference was 24.2 cm in the injured right, 23.5 cm in the injured left.

Examination of the wrists revealed no evidence of lymphangitis or cellulitis. The wrists had a normal temperature, texture, tone and appearance. There were no abnormal masses such as a ganglion. There were no hypersensitive areas or scars. There was a full range of motion and good strength in all directions. Normal range of motion bilaterally. Provocative testing of the wrists revealed there was no tenderness of the distal radioulnar joint, radiocarpal joint or over the triangular fibrocartilage complex. There was slight pain on forced dorsiflexion or palmar flexion and discomfort over the radial extensors on the left, but not on the right. There was no clicking, popping or joint noise. Ulnar impingement, lunotriquetral ballottement, Watson maneuver, snuffbox tenderness and hamate hook discomfort testing were normal bilaterally.

Examination of the hand/digits revealed the hand had a normal appearance, texture and tone. There were no masses. There was evidence of triggering and A-1 pulley tenderness

of the left index and long fingers. There was evidence of tendinitis on the left. All extrinsic and intrinsic motors were intact and functional. The pulp to palm distance was marginally increased on the left. There was no evidence of ligamentous instability nor laxity. The grind test was normal, but the Finkelstein test was positive on the left. Index finger MCP flexion was 85 on the right and 75 on the left, PIP 100 on the right and 90 on the left and long MCP was 75 on the left and PIP 90 on the left. Radial abduction was 90 on the right and 80 on the left. Right thumb misses the head of the little finger by 0 cm. Left thumb misses the head of the little finger by 0 cm. All other range of motion was normal. Grip strength was 22/22/21 on the right and 10/9/8 on the left. Pain in the left palm when squeezing. Pinch strength was 3/3/3 on the right and 2.5/2.5/2.5 on the left. The radial and ulnar arteries were palpable. The hand had a normal temperature, texture and tone. Sudomotor function and capillary refill were normal. The Allen test was normal. Provocative test including Adson's, costoclavicular and Wright's maneuver were normal. There was no evidence of a vascular insufficiency problem nor of a thoracic outlet syndrome. The ulnar and radial nerves were intact. There was median nerve irritability on the right. There was normal sensation to moving two-point discrimination and touch. Dexterity, stereognosis, and sudomotor functions were normal. There was no evidence of atrophy in either the median or ulnar innervated intrinsics. The Phalen's test was positive for the right median nerve. The direct nerve compression test was weakly positive for the right median nerve. Tinel sign wrist and forearm were negative bilaterally. Phalen's test positive on the right and negative on the left. Direct nerve compression weakly positive on the right and negative on the left. Pronator resistance negative bilaterally. Ulnar nerve: Tinel sign wrist/elbow, Phalen's test, direct nerve compression, Froment sign and flexion/extension test negative bilaterally. Radial nerve Tinel sign wrist/forearm, extensor mass tenderness, resisted supination and long finger extension test negative bilaterally.

Dr. ***** indicated the patient appears to have carpal tunnel syndrome on the right side. There is no indication of carpal tunnel syndrome on the left. She, however, is complaining about pain radiating down from her neck, which indicates that there are some residuals following what appears to be a multilevel fusion.

Dr. ***** indicated x-rays of the left hand revealed no evidence of fracture, dislocation or degenerative change. Joint spaces were all normal. There was no evidence of an arthritic condition. The soft tissues were normal. There was no abnormal calcification in the musculature or elsewhere. Bone mineralization and architecture were normal. There was no evidence of disuse osteopenia. The left-hand x-rays were normal.

X-rays of the right hand revealed there were some minimal changes in the distal interphalangeal joints of the long and little fingers, a finding of no significance. There is otherwise no evidence of a fracture, dislocation or degenerative change. Joint spaces were all normal. There was no evidence of an arthritic condition. The soft tissues were normal. There was no abnormal calcification in the vasculature or elsewhere. Bone mineralization and architecture were normal. There was no evidence of disuse osteopenia. The right-hand x-rays were normal. Notable is that bone density was normal in both hands.

X-rays of the cervical spine revealed she has undergone a multilevel fusion. She does have an anterior plate with screw fixation at C5-6 and C6-7. There is a loss of the normal cervical lordotic curve. There are also some degenerative changes above the fusion. The finding is consistent with a cervical discectomy and multilevel fusion as well as some degenerative spondylosis at C4-5.

Dr. *****'s impression was she has an exceedingly complex medical history and the enormous stack of medical records have been reviewed. She had undergone a series of knee operative procedures, including a total knee replacement due to a nonindustrial motor vehicle accident.

Dr. ***** noted the patient did have a series of injuries to her neck, including being assaulted by family members as well as by patient's, working as a mental health technician. She was given 8% whole person impairment by Dr. *****, the AME. However, she had not yet undergone and operative procedure at that time and it appears she has undergone a multilevel fusion at C5-6 and C6-7.

After the neck procedure, she did not return to work as a healthcare technician, but commenced her job duties in an office setting and she returned to work apparently in [redacted]. She then had her job modified and apparently worked in the medical billing until [redacted]. She then apparently was out on an administrative leave of absence and returned to work in a different position, also as and office technician in February [redacted]. She developed pain and numbness in the right hand in [redacted] and symptoms on the left and stopped work on [redacted] due to the restriction given her. She returned to a modified job in [redacted] and continues at this time, but does have some problems related to her upper extremities. She states that her neck pain has been relatively stable.

Dr. ***** indicated subjective complaints include the following:

1. Slight to intermittent pain in both hands and wrists, but will increase to slight to moderate on the right and moderate and intermittent on the left with extensive use.
2. Tingling and numbness in both hands, right greater than left.
3. Stiffness and locking, digits of left hand.
4. Decreased strength.
5. Difficulty pinching and grasping, left greater than right.
6. Night pain bilaterally.
7. Swelling with use, left greater than right.
8. Stiffness, neck.
9. Some nonspecific tingling shoulder girdle/neck.

Dr. ***** indicated objective findings include the following:

1. Grip strength loss estimated to be 10% right side, 35% on the left.
2. Pinch strength loss 25% bilaterally.
3. Median nerve irritability, right.
4. Locking, index and long fingers, left, consistent with tenostenosis.
5. Tenderness, dorsoradial aspect of left wrist, with positive Finkelstein test, consistent with de Quervain's. 6. Motion loss, neck, due to prior fusion.

Dr. ***** indicated the current diagnosis are as follows: Carpal tunnel syndrome, right side and tenostenosis, including triggering of two digits and de Quervain's on the left. There is a suggestion historically of mild carpal tunnel syndrome on the left, but it cannot be confirmed either clinically or electrodiagnostically. Of note is that the patient had denervation and re-innervation in the ulnar territory, but there is no indication of a cubital tunnel syndrome and one always has to interpret any diagnostic study in the clinical context of the patient's presentation.

Dr. ***** indicated the patient's problems in the upper extremities are due to continual trauma. The continual trauma period would best be described as the one-year period to her seeking medical attention, namely [redacted].

Dr. ***** indicated she is not permanent and stationary. She has not received adequate care, so it does seem somewhat premature to assign her a rating using either the old or new guidelines. She is going to need some work restrictions of no very repetitive grasping, pinching, holding, twisting, torqueing or flexion/extension and no activities requiring very repetitive fine finger manipulation or finger dexterity, which is a 25% loss of her pre-existing bilaterally. She will also need an ergonomically correct work station.

She does have carpal tunnel syndrome. If she is still symptomatic, I would recommend an endoscopic or limited open carpal tunnel release on the right side. At the same time, I would inject the A-1 pulley of the index and long finger and also the first dorsal compartment on the left. She might need two or three weeks of physical therapy after the carpal tunnel release. If the triggers recur, she might need injection a second time. She may also need two or three injections for the de Quervain's. If this does not help, she may need a tenovaginotomy for the triggers and de Quervain's.

Dr. ***** indicated that her hand/wrist problems are 90% due to continual trauma and 10% are due to other factors, including pre-diabetes, obesity and being perimenopausal. She can return to Dr. ***** to see if he thinks there is any additional impairment associated with the neck.

Dr. ***** indicated in the interim, until the surgery is done, I would recommend that she wear night splints bilaterally. It does appear that as long as her work station is ergonomically correct, she should be able to return to work.

Dr. ***** indicated with regard to impairment rating, on the right side, the patient had a completely normal range of motion. The regional impairment is 0%. In looking at Tables 16-10, 11 and 15, with a history consistent with carpal tunnel syndrome, nerve irritability and a positive nerve study, but no actual loss of moving two-point discrimination, the patient has carpal tunnel syndrome grade 4, with a 20% loss times 39%, the sensory value of the median nerve, which is 8%. There is no ratable loss of strength, so the strength loss index is not applicable. The whole person impairment on the right is 5%.

Dr. ***** indicated on the left side, she is actually more symptomatic due to the tenostenotic problem with locking, quantified using Table 16-29, for the index and long fingers, resulting in a 16% hand impairment or 14% upper extremity impairment. There is normal motion elsewhere, so the regional impairment is 14%. There is no indication of a neuropathy clinically but she does have evidence of synovitis at the wrist level, which is quantified using Table 16-19 as mild, with a 10% loss, times 60%, the value of the wrist, which is 6%. Combined 14% and 6%, is 19% upper extremity impairment, which is 11% whole person impairment. If we combine 11% and 5%, we have a whole person of 15%, since the patient has a bilateral condition. I would add on 3% for the activities of daily living, which means that her whole person impairment is 18%. Of this, 90% is work related. Thus, as a consequence of her industrial exposure, until the situation is resolved, her temporary whole person impairment is going to be 16% due to her industrial exposure. Once treatment is instituted and if it is successful, hopefully her whole person impairment will actually decrease. She should be returned to this office probably six

months after the last operative procedure, so that an accurate whole person impairment and permanent and stationary report can be issued.

Dr. ***** recommended that she return to a board-certified upper extremity expert to have the situation remedied. The patient, if successful – and the chance of success is 90% - will be able to continue to work as an office assistant, obviating the need for supplemental benefits.

[redacted]

There is a Report of MRI of the right shoulder from ***** *****, M.D. dated [redacted] Ordered by ***** *****, M.D.

Impression:

1. Rim rent tear of the anterior fibers of the supraspinatus tendon. No full thickness tear.
2. Extensive degenerative changes at the acromioclavicular joint with associated fluid and inflammatory change which impinge on the musculotendinous portion of the supraspinatus.
3. Type 2 acromion.

There is a Report of Electrodiagnostic Evaluation from ***** *****, M.D. dated [redacted]. Nerve conduction study was performed of both upper extremities and EMG was performed of the ulnar territory bilaterally and the right shoulder girdle muscles. The patient was unable to tolerate further study.

Impression:

1. Normal nerve conduction studies both upper extremities. The left median mid-palmar latency is borderline, however – a borderline finding for carpal tunnel syndrome. The right median mid-palmar latency is borderline (post-operatively).
2. Changes of denervation and reinnervation in the ulnar territory bilaterally and in the right cervical myotomes.

Comment: In an appropriate clinical context this study would support a clinical diagnosis of bilateral cubital tunnel syndrome. Care should be exercised in

interpreting the above abnormalities in the right cervical territory, as the patient is postoperative. As compared with the study of [redacted], this is improvement in the right median study, but otherwise there is no remarkable change.

There is a Report of X-rays of the right shoulder from ***** ***** ***** ***** Imaging Center dated [redacted]. Ordered by **********, M.D.

Impression: Degenerative change which is mild at the acromioclavicular joint.

X-rays of the cervical spine were also performed.

Impression:

1. Status post anterior cervical discectomy and fusion procedure at C5-6 and C6-7.
2. Mild interval increase in the degree of degenerative spondylosis at C4-5.

There is another Agreed Medical Examiner's Report from Dr. ***** dated [redacted]. Dr. ***** indicated according to the records; the patient underwent a right carpal tunnel release on [redacted]. She was placed on disability and she was seen in follow-up postoperatively. She was provided with postoperative physical therapy and Norco and Cipro.

Dr. ***** noted the findings of the MRI of the right shoulder done on [redacted].

The patient states she returned to work in [redacted] with restrictions. She was seen at ***** County Health Care on [redacted] for her right shoulder and was diagnosed with tendonitis and a rotator cuff tear. A surgical consultation with Dr. ***** was requested for an arthroscopy shoulder distal claviculectomy, shoulder scope bone shaving and arthroscopic shoulder rotator cuff repair. Dr. ***** reviewed the MRI and indicated the patient was suffering from severe bony impingement syndrome at the level of the shoulder. She also continued to complain of residual pain from the cervical spine and a cervical spine disc surgery was recommended as well as a left carpal tunnel release and trigger finger and adhesive tenosynovitis of the flexor tendon of the long finger of the left hand at the level of the A-1 pulley parallel the level of metacarpophalangeal joint.

Dr. ***** indicated she states to me that she was injured by a patient at work and although not available, a report by Dr. ***** on [redacted] indicated she was tackled by a patient months' earlier and hurt her shoulder. The patient states authorization for

right shoulder surgery is still pending and she is receiving State Disability Benefits. She continues to be symptomatic.

The patient complained of pain in left hand and wrist and right shoulder and neck, stiffness in left hand, neck and right shoulder, decreased strength in hands and wrists, swelling in hands, wrists and right shoulder; sensitivity in hands and right shoulder, night pain in hands, wrists and right shoulder and numbness in hands and wrists and right shoulder.

X-rays of the right shoulder revealed she did have degenerative changes seen in the acromioclavicular joint. There was no evidence of fracture or dislocation. There was no calcification in the rotator cuff. The glenohumeral joint space is maintained. There is no evidence of glenohumeral collapse to go along with a complete rotator cuff tear. The findings are longstanding.

X-rays of the cervical spine revealed there appeared to have been a minimal increase in the degree of degenerative spondylosis at C4-5, comparing this x-ray with that done in [redacted].

Dr. ***** indicated any problems related to the knee are unrelated to her employment. The patient did sustain two industrial injuries as well as a nonindustrial injury to the neck and left arm and treated primarily for these injuries initially with Dr. ***** at the ***** County Medical Center and then with Dr. **********, a skilled orthopedic expert who noted a problem in her neck, but not in her shoulder. The patient's pain radiated from the neck into the right upper extremity and based upon her clinical presentation and MRI and diagnostic studies, Dr. ***** recommended conservative care. There was no mention of any problems in her shoulders in Dr. *****'s many reports.

Dr. ***** indicated the situation was then clarified by Dr. ***** in his report of [redacted] and he concluded that her neck problems were multifactorial, but primarily based upon the two industrial injuries and came up with a whole person impairment of 8%. There was no mention of any problems in the patient's right shoulder in any of the reports from Dr. ***** or Dr. *****. Thus, in agreement with the denial, there really was no indication that she injured her right shoulder in [redacted].

Dr. ***** noted when examined in my office on [redacted], her right shoulder was completely normal, with no indication of impingement or rotator cuff tendinosis. She underwent carpal tunnel release with Dr. ***** on [redacted] with an exceedingly long incision. She did have some postoperative problems and apparently was felt to have

cellulitis seven weeks after the surgery and was put on Cipro, but was able to return to work in early [redacted].

Dr. ***** noted a report from Dr. ***** indicated that she sustained trauma to her shoulder when she was tackled by a patient some six months earlier, exact date unknown. I could not find a first report of injury, and Dr. ***** continued to echo the need for shoulder surgery first noted in his report of [redacted]. He stated on [redacted] that she was supposed to have shoulder surgery in the past. However, I see no indication that anyone ever mentioned the need for shoulder surgery. There was some equivocal evidence of transient tendinosis in [redacted], but no indication that anyone recommended surgery.

Dr. ***** indicated when the patient was seen on [redacted], Dr. ***** noted abduction and flexion of only 75 degrees. It is interesting that when the patient was seen in my office one and a half years ago, she had normal motion and when seen in my office on [redacted], she had 160 degrees of flexion and abduction. I see no indication that she received any type of appropriate conservative care for her shoulder and Dr. ***** was not only recommending shoulder surgery, but also trigger release and carpal tunnel surgery on the left side. It should be noted that the patient is essentially electronegative on the left, and never had a provocative cortisone injection.

Dr. ***** indicated the patient stated to me that her shoulder pain increased in [redacted], and whether or not a new injury occurred is unclear. Suffice it to say, when I examined her in [redacted], there was no indication of impingement or tendinosis, so in agreement with the letter from ***** *****, the senior claims specialist, dated [redacted], there is no indication that she injured her right shoulder in the industrial accident that occurred on [redacted] and that is based upon a review of all of the prior medical records in my possession, combined with the findings of both Dr. ***** and Dr. *****, both highly-skilled orthopedic shoulder experts of AME quality.

Dr. ***** indicated thus, the current problem with her shoulder appears to be new, and if indeed she was tackled by a patient, exact date unknown, and landed on her right shoulder, the changes in her right shoulder did occur subsequent to the time I last examined her.

Subjective complaints: Slight and intermittent pain in the right hand and wrist, increasing with very extensive use to moderate; slight, intermittent pain right shoulder increasing to moderate with extensive use, the patient states that the pain is severe, but at no point in time did she appear to be in any severe pain; tingling mostly in the little and ring fingers

of both hands and occasionally in the thumb, index and long, left; some stiffness and occasional locking left long finger; decreased strength, stiffness in the neck; occasional night pain, mostly due to right shoulder.

Objective findings: Grip strength loss estimated to be 25% on the right, 15% on the left; normal grip strength should be in the vicinity of 25-27 kg on the right and 21-23 kg on the left. The patient appeared to be using fairly good effort in doing the strength determination. Some ulnar nerve irritability bilaterally, with marginal loss of sensory perception, ulnar nerve, right side only. A marginal loss of motion and strength, right shoulder with evidence of tendinosis. Healed anterior neck scar and motion loss, due to old fusion procedure. Some median nerve irritability, but no loss of sensory perception. Some tenderness A-1 pulley, left long finger, but no locking at this time.

Dr. ***** again indicated that any problems in the shoulder are unrelated to her injury of [redacted]. She did undergo a carpal tunnel release with a nice result and the loss of strength in her grip appears to be due to some new conditions, exact etiology unclear, but if indeed she was pulled to the ground by a patient and hit her shoulder and of course, I have no first report of injury for that – the shoulder problem is indeed industrially related but not to the injury of [redacted]

Dr. ***** indicated the diagnoses in this case is status post multilevel fusion of neck with residuals due to a combination of industrial and nonindustrial injuries as quantified by Dr. ***** *****, the AME in orthopedic surgery, who previously evaluated her; nonspecific left shoulder pain, currently asymptomatic; mild carpal tunnel syndrome on the right side, corrected; questionable carpal tunnel syndrome on the left, inadequately treated; tenostenosis, left hand, improved; and minimal cubital tunnel syndrome bilaterally. The patient also appears to have a new condition, namely rotator cuff tendinosis, which occurred sometime between my examination of her in [redacted] and my examination of [redacted].

Dr. ***** indicated there is no indication of what I would consider to be dysfunctional behavior, nor are there any nonphysiological findings, but there appears to be an element of symptom magnification in her articulation of her complaints, and as can be seen, this woman does have some psychological problems, etiology to be discussed by an AME in psychiatry.

Dr. ***** indicated she was working when I last saw her. It appears she could continue to work until she underwent the carpal tunnel release performed on [redacted]. Most patients with carpal tunnel syndrome can usually return to work within two months,

but she developed cellulitis, noted on [redacted]. It is unclear what was done for her left hand. She certainly should have had the first dorsal compartment and A-1 pulleys injected with cortisone on the left side while she was sedated for her carpal tunnel release. It is most unusual to develop any type of infection after a carpal tunnel release and I am somewhat concerned about the length of the scar. Most scars of carpal tunnel releases veer towards the ulnar aspect and this actually goes towards the radial aspect. The reason for pointing this out is, it is fortunate that the palmar cutaneous nerve was not damaged.

Dr. ***** noted she stopped work in [redacted] and surgery for the shoulder has been recommended, but it is unrelated to the injury of [redacted]. I would consider her to be partially disabled, capable of employment with some restrictions even though she does have some problems with her shoulder. I might add, there is quite a difference in measurements between the values of Dr. ***** on [redacted] with 75 degrees of abduction and flexion and when seen in my office, where the patient had 160 degrees of abduction and flexion.

Dr. ***** indicated thus, I do feel that the patient could have continued to work with some restrictions and hence she was never temporarily totally disabled.

Dr. ***** indicated if indeed she did sustain an injury to her shoulder when she was tackled by a patient, date unclear, then I would agree that she needs treatment for her shoulder due to that new injury, but not due to the injury of [redacted]. If the shoulder problem was not documented and occurred at home or as a consequence of treatment for her knee (from use of crutches), then of course it would be considered nonindustrial and if that case is true – and would be more than willing to review all of the additional records, especially those of Dr. ***** and others, concerned with what transpired between my earlier assessment and the current one – then the shoulder should be treated on an nonindustrial basis. However, if it did occur at work, then treatment for the shoulder would be appropriate and she would not be considered ratable at this time, since she wishes to proceed with treatment for the shoulder. However, I would respectfully disagree with all of the recommendations of Dr. *****.

Dr. ***** indicated the patient is going to need a restriction, if indeed the right shoulder is due to a new injury, of no repetitive heavy work overhead and no very heavy lifting and carrying. For the continual trauma claim, she would need a restriction of no very repetitive forceful pushing and pulling, gripping, grasping, pinching, holding, twisting, torqueing or flexion/extension with a similar magnitude. Loss of her pre-injury capacity for fine finger manipulation or finger dexterity, estimated to be 17%.

Dr. ***** indicated for the ulnar nerve irritability – and I might add, there is a loss of sensory perception now that was not present when I last examined her – she should have been given some Pil-O-Splints. Thus, it does appear that the treatment to date has not really been the best for her. She should have had a cortisone injection into the shoulder for the rotator cuff tendinosis. It should be noted that in looking at the MRI results, there is no indication of a significant rotator cuff tear.

Dr. ***** indicated it appears that the shoulder problem, if indeed a new injury occurred, is due to the new injury. 70% of it is due to continual trauma, 20% is due to the alleged new injury to the right shoulder and 10% is due to nonindustrial conditions.

Dr. ***** indicated she was noted to have carpal tunnel syndrome on the right side. That is definitely improved, even though the incision is not the best. However, electromyographically there is no indication of carpal tunnel syndrome. Thus, before surgery is carried out, I would recommend a cortisone/Xylocaine injection into the carpal canal as a provocative test. If the tingling and numbness disappear, only to return, then Dr. ***** should be authorized to proceed. However, I certainly would not use the same incision, for fear of damaging the palmar cutaneous nerve. The tenostenosis is better. I would recommend a cortisone/Xylocaine injection into the A-1 pulley of the long finger and if that does not solve the problem, a percutaneous or limited open release could be done.

Dr. ***** indicated in terms of her elbows; she now has a loss of sensory perception not noted in the past. Here, I would recommend Pil-O-Splints. These should be worn at home and at night. She is not a candidate for any surgery at the elbow level.

Dr. ***** indicated with regard to impairment rating, the loss of motion in the shoulder is 4%. She has carpal tunnel syndrome, corrected, grade 5 with 0% impairment. However, she does have some evidence of mild cubital tunnel syndrome now, with some sensory loss and denervation and re-innervation. She is now a cubital tunnel syndrome grade 4, with a 10% loss times 50% which is 5%. She does not qualify for the strength loss index. Thus, if we combine 5% and 4%, we have 9% upper extremity. Which of course is 5% whole person. I would give her an add-on of 2% for pain, bringing it up to 7%.

Dr. ***** indicated on the left side, there is some tenderness in the A-1 pulley but no actual locking. That is a 4% hand impairment. There is normal motion elsewhere. There is minimal median nerve irritability, but she is electronegative. She would be grade 4,

with a 5% loss times 39% which is 2%. She has cubital tunnel syndrome, grade 4 with a 10% loss times 46%, the motor value of the ulnar nerve since there is no sensory loss, which is 5%. Combining 5% and 2% we get 7%. Then combining 7% and 4% we have an 11% whole person impairment, which is 7% of the whole person.

Dr. ***** indicated if we combine 7% for the left side and 5% for the right, we have a 12% whole person impairment. I would also give her an add-on of 2% for pain, which means her new whole person impairment is 14%. If the shoulder problem is indeed work related, then 90% of the 14% is work related and 10% is nonindustrial.

Dr. ***** indicated the patient can return to work in an office, but would have difficulty taking care of belligerent inmates. Apportionment is going to be applicable in this case with 10% of the 14% whole person impairment related to factors unrelated to her industrial exposure. The patient is going to need appropriate treatment for her shoulder, if indeed it is industrial.

[redacted]

There is a Doctor's First Report of Injury from ***** ***** ***** ***** Center, ***** *****, M.D. dated [redacted]. The patient is a [redacted]-year-old female with neck and right shoulder complaint for about eight years. On [redacted] she was working as a mental health nurse when a patient grabbed her by her hair and she was being yanked back and forth by the patient. She was sent to the emergency room immediately and they evaluated her and she was off work for a few weeks.

She had neck surgery in [redacted] with Dr. *****, which she states helped with her pain. She had physical therapy following surgery. She has not had an MRI since surgery. She has not had any injections, chiropractic treatment or acupuncture since neck surgery. She was seen by Dr. ***** and Dr. ***** for her surgery. She says surgery was requested for the shoulder. She had injections for the shoulder which helped temporarily. She had EMG/nerve conduction studies for her bilateral upper extremities. She is currently working modified duty.

She has had several prior workers' compensation claims for the right hand and left hand, but denied motor vehicle accidents. She denied prior significant neck or shoulder complaints.

She currently complains of persistent neck and right shoulder pain which she currently rates 10/10. She says she can barely turn her neck and feels it is worsening with time. She reported radiation of pain down the right arm to the elbow. She feels a constant burning and pins and needles sensation in her right shoulder. She uses an arm sling to help eliminate the amount of movement.

Her past medical history includes neck surgery [redacted], left trigger finger surgery [redacted] right carpal tunnel release [redacted] knee replacement, C-section. Medications include Xanax, tramadol, Neurontin and Norco 10/325.

Examination revealed cervical range of motion was flexion 30 degrees, extension 10 degrees, right/left lateral bend 5 degrees and right/left rotation 20 degrees. There was decreased sensation C7 and C8 dermatomes on the left. Motor: Deltoid, biceps, internal rotators, wrist extensors, wrist flexors, triceps, and interossei were 4+/5 bilaterally. Reflexes: Bilateral upper extremity and lower extremity reflexes were intact. Negative Hoffmann's, Negative Babinski, no clonus.

X-rays of the cervical spine were performed and revealed there was a cervical fusion from C5 through C7. The fusion is probably solid, although there were slight halos around the hardware on several views, which may indicate pseudoarthrosis. There is moderate to severe disc space narrowing at C4-5. There were anterior osteophytes evident at C4 and C5.

The diagnoses were "1. Status post cervical fusion at C5-6 and C6-7. 2. Chronic neck pain. 3. Cervical radiculopathy."

Dr. ***** indicated that with regard to causation, the patient did sustain an injury AOE/COE to the neck.

Dr. ***** requested a general orthopedic consultation with Dr. ***** for bilateral upper extremity evaluation in order to determine whether or not there is an industrial component to these areas and whether or not treatment or testing is required on an industrial basis. He also requested an MRI of the cervical spine and a trial of acupuncture for the neck and upper extremities at two times a week for four weeks. She was provided Norco and Tramadol. Labs prescribed to monitor liver and kidney function.

There is an Orthopedic Consultation Report from ***** ***** ***** ****** , ***** *****, M.D. dated [redacted] The patient complained of pain in the right shoulder since date of injury [redacted] when a patient grabbed her hair and she was being yanked

back and forth. She denied prior significant neck and shoulder complaints. She rated her right shoulder pain at 8/10 and there is radiation of pain down the right arm to the elbow and constant pins and needles sensation in the shoulder.

Examination of the right shoulder revealed there was no swelling, deformity or effusion. There was no bone or joint malalignment. There were no abrasions, lacerations or skin breakdown. There was no erythema, ecchymosis or discoloration. AROM and PROM: Flexion 180 degrees, extension 60 degrees, abduction 180 degrees, external rotation (side) 45 degrees, external rotation (90 degrees) 90 degrees and internal rotation (90 degrees) 70 degrees. There was tenderness to palpation to the entire shoulder. There was no skin hypersensitivity. There was pain with range of motion. The joint was stable and tracked well with range of motion. There was no instability with manipulation or weight bearing. Neer's positive, Hawkins positive, Yergason's negative, Speed's negative, O'Brien's negative, apprehension negative, relocation negative, sulcus negative, drop arm negative and cross arm negative.

Neuro: Strength 5/5 interossei, thenar, ECR, biceps and deltoid. Sensation normal to radial, median, ulnar and axillary nerves. Deep tendon reflexes 2+ biceps, brachioradialis and triceps. 2+ pulses to radial and ulnar arteries. Less than 2 second capillary refill.

X-rays of the right shoulder demonstrate chronic AC arthrosis and mild glenohumeral arthritis.

The assessment was "Right shoulder impingement/bursitis."

Dr. ***** indicated at this time we will proceed with conservative treatment consisting of observation until records are available. Weight bearing as tolerated. Work restrictions: 15 pounds single lift, 5 pounds repetitive, 0 pounds overhead. I believe the patient sustained an injury AOE/COE to the right shoulder. Request for medical records.

There is a Report of MRI of the cervical spine from ***** *****g dated [redacted] Ordered by Dr. *****.

Impression:

1. Anterior fusion with plate and a screw fixation and interbody spacers is seen from C5-C7 without evidence of hardware failure, loosening or infection.
2. Mild straightening of the cervical lordosis.
3. Degenerative discogenic spondylosis primarily at C4-C5 and T1-T2.

4. The C2-C3 through C4-C5 intervertebral discs are desiccated and the C4-C5 disc is reduced in height.
5. C4-C5: A 2.8 mm broad-based central disc protrusion deforms the ventral thecal sac. Facet and uncovertebral arthrosis contribute to moderate neuroforaminal narrowing with encroachment of the exiting nerve roots.

There are Progress Reports from Dr. ***** dated [redacted] and [redacted] She rated current neck and right shoulder pain at level 8/10. She had left carpal tunnel release surgery on [redacted] with Dr. *****. The findings of the MRI of the cervical spine done on [redacted] were noted. She has had 3 sessions of acupuncture which has helped alleviate her pain somewhat. She is currently taking Norco and tramadol. She notes strange dreams and does not like taking tramadol. She says that these medications have helped to alleviate her pain by about 60-70% and help her regain function and complete activities of daily living. She last worked on [redacted]

Dr. ***** noted MRI showed disc herniation and facet arthropathy at the level above the fusion at C4-5. I do request a medial branch block of the cervical spine at C4-5. Future considerations include a rhizotomy. She was recommended continued acupuncture. A CT of the cervical spine was also requested. She was prescribed Norco and Neurontin.

There are Acupuncture Records from ***** ***** ***** ****** dated from [redacted] through [redacted] indicating the patient received 4 treatments of manual acupuncture and infrared for neck pain radiation down right arm and right shoulder pain, status post cervical fusion C5-6 and C6-7 and cervical radiculopathy. Following treatments, she reported she was the same.

There is a Report of CT scan of the cervical spine from ***** Imaging Centers dated [redacted] Ordered by Dr. *****.

Impression:

1. Retrolisthesis C4-5 with degenerative disc disease noted and postoperative changes of anterior fusion C5-6-7.
2. Canal stenosis includes C4-5 moderate canal stenosis.
3. Neural foraminal narrowing includes C4-5 moderate to severe right and C5-6 moderate right neural foraminal narrowing.
4. Degenerative disc disease is seen in the proximal thoracic spine.

There is a Progress Report from Dr. ***** dated [redacted] Due to failure of non-operative treatment at this point, Dr. ***** recommended operative treatment in the form of right shoulder arthroscopy with subacromial decompression, distal resection and debridement. Based on the chronicity of her pathology and the response to conservative treatment I estimate 60% recovery. This could include residual pain as well as ongoing dysfunction. Preoperative consultation for clearance was requested as well as preoperative studies. Authorization was also requested for postoperative durable medical equipment including sling, ice therapy/cold therapy and chiropractic therapy.

There are Progress Reports from Dr. ***** dated [redacted] and [redacted] The patient reported having difficulty with memory, which she attributes to difficulty sleeping. She expressed concern about being on medication long term and "just wants to get better." Dr. ***** recommended continued acupuncture. She was prescribed a soft neck collar to wear as needed. She was continued on medications. Dr. ***** continued to request medial branch block bilateral at C4-5.

There is a Procedure Report from ***** Surgery Center, ***** *****, M.D. dated [redacted]

Procedure:

1. Cervical facet medial branch block, bilateral C4-5.
2. Review of records.

There were no complications.

There are additional Progress Report from Dr. ***** dated [redacted] and [redacted] She has had MBB bilateral C4-5 and states she received about 60% relief for about one day and allowed her to move her neck. Now she reports that her pain has returned and is quite severe. Dr. ***** recommended a rhizotomy bilateral C4-5. She was continued on medications.

There is another Procedure Report from ***** Surgery Center, Dr. ***** dated [redacted]

Procedure:

1. Radiofrequency facet joint nerve, right C4-5.
2. Fluoroscopy for spinal injections.

The patient tolerated the procedure well without complications.

There is a Progress Report from Dr. ***** dated [redacted] The patient reported she had complete relief of pain for 5 days after cervical rhizotomy, but the pain increased with time and she currently rated her neck pain at 6/10. She continues to have severe right shoulder pain and is awaiting authorization for a right shoulder surgery. The patient was advised that she may still obtain more relief from the procedure. She was continued on medications.

There is a Progress Report from Dr. ***** dated [redacted] The patient continued with right shoulder pain and Dr. ***** again requested surgery.

There is a Report of EMG/nerve conduction studies from ***** *****, M.D. dated [redacted] Referring physician: **********, M.D.

> Impression: Sub-maximal force generation observed in all muscles tested during EMG study may be due to pain (either pre-existing and/or exacerbated by EMG needle insertion); reduced effort on a volitional basis; and/or upper motor neuron disorders. Clinical correlation is advised. The above electrodiagnostic study revealed no evidence of cervical radiculopathy, bilateral cubital and/or carpal tunnel syndrome.

There is a Report of X-rays of the right shoulder from [redacted] dated [redacted] Ordered by Dr. *****.

> Impression: Degenerative changes with development of calcific tendinopathy of the rotator cuff tendon.

X-rays of the left hand were also performed.

> Impression: No acute pathology.

X-rays of the right hand were also performed. Comparison with [redacted]

> Impression: No interval change.

On [redacted] Dr. ***** requested a pain management consultation with Dr. ***** for her continued neck pain. She was continued on gabapentin.

There is a Pain Management Consultation Report from ***** ***** ***** ****** , ***** *****, M.D. dated [redacted] Dr. ***** indicated medications will be continued as prior, the current regiment has been used appropriately and has been effective to increase activity and decrease pain. Ibuprofen 800 mg will be used. She was prescribed Norco and gabapentin.

There is a Progress Report from Dr. ***** dated [redacted] The patient reported increased headaches. Since picking up the Norco from the pharmacy, she has had increased constipation and diarrhea. She tried substituting Norco for Tylenol #3, however, she had to take three of the Tylenol compared to the one Norco to manage her pain and this resulted in headaches. She is now out of medication. She would like to switch back to Norco and try getting it from a different pharmacy to avoid the side effects. Tylenol #3 will be discontinued and Norco will be restarted. She was continued on Ibuprofen 800 mg and gabapentin.

There is a Progress Report from Dr. ***** dated [redacted] She continues to await authorization for right shoulder arthroscopy with subacromial decompression, distal resection and debridement. This is currently denied due to denied body part. She has ongoing follow-ups with Dr. ***** for her right hand. She is scheduled for a cervical interlaminar steroid injection targeting right C4-5/5-6 at the ***** Surgery center this Friday, [redacted] She rated her right shoulder pain at 9/10. Her pain is somewhat increasing with time. There is radiation of pain and constant pressure in her right shoulder and pectoralis regions. She denied radiation to her elbow. She states her thumb is numb when she wakes up in the morning. Dr. ***** continued to recommended surgery.

There is a Procedure Report from ***** Surgery Center, Dr. ***** dated [redacted]

Procedure:

1. Cervical epidural C4-5/5-6.
2. Injection via catheter.
3. Epidurography.
4. Fluoroscopy for spinal injections
5. Review of records.

There were no complications and the patient tolerated the procedure well.

There are Progress Reports from Dr. ***** dated [redacted] and [redacted] The patient reported she had about 50% relief from the injection. She currently rates her neck pain at 4/10. Her biggest concern at this time is having urinary incontinence about two days ago. She says she is having to wear pads because she cannot control her urine. She says the urinary incontinence is unpredictable and occurs throughout the day. She denied any numbness in her groin region and says she has some mild low back pain. She continues to have right shoulder pain. She has had some pain relief in her neck since the recent epidural injection.

Dr. ***** advised her to go to the ER immediately to further evaluate her urinary incontinence. Pain management follow up was requested with Dr. *****.

There is a Supplemental Report from Dr. ***** dated [redacted]. Dr. ***** noted that if the patient only worked for 4.6% of the time from [redacted] to [redacted], it would be medically improbable that she sustained a continual trauma injury during that period of time. It is medically improbable that anyone is going to develop rotator cuff tendinosis or impingement or tenosynovitis with that amount of hand activities, especially if she was only working four hours per day during that short period of time.

Dr. ***** indicated it is therefore concluded that the problem of the right shoulder and the tenostenotic problem are unrelated to her industrial exposure with the County of ***** and are secondary to events that occurred outside of her work experience. Thus, if the assumption is correct, I am going to have to modify my opinion and state that there actually was not sufficient time for the patient to develop a continual trauma problem, especially after reviewing the x-rays of her shoulder, which indicate longstanding changes, consistent with her age and gender.

[redacted]

There is a Progress Report from Dr. ***** dated [redacted]. The patient reported her right shoulder pain has worsened and continues to worsen with time. She continues to await right shoulder surgery. She says that the cervical steroid injection on [redacted], provided good relief to her neck but now pays more attention to the right shoulder pain. She rated the right shoulder pain at 8/10. Her pain has limited her daily activities, such as drying her hair and she reported difficulty sleeping. She is unable to perform any activities that involve lifting her hands above her head. Dr. ***** continued to recommend right shoulder surgery.

In a Report dated [redacted], Dr. ***** reviewed surveillance video on the patient. Dr. ***** indicated the films do not refute anything that was told to me by the patient. The videos showed her performing her typical activities throughout the day on various days in [redacted] She is mostly seen performing very light activities, except one particular day when she is doing some work in front of her house, which involves vacuuming and lifting a propane tank. The patient has told me she has increased pain when raising her arm overhead and with driving, however, the video does not reflect if the activities shown caused her pain or not. The video does not change my opinion or belief regarding the patient's credibility.

Dr. ***** indicated since she has been under my care, she has been declared permanent and stationary. There have been no periods of temporary disability and her condition has remained permanent and stationary while she has undergone the ongoing treatment for her neck while under my care. My opinions remain unchanged regarding the disability status. The films do not change my opinion regarding anything else in this case.

There is a Progress Report from Dr. ***** dated [redacted]. The patient reported she continued to have pain relief following the injection for about eight weeks. The benefits have worn off. She states that following the epidural injection she started to have urinary incontinence which eventually resolved but then returned about two days ago. She is seeing her primary care physician for her urinary issues. She reported persistent throbbing right sided neck and right shoulder pain rated 8/10.

Dr. ***** noted she says she has difficulty sleeping, getting dressed and taking a shower due to her severe neck and shoulder pain. She says she is now considering surgery for her neck. Future considerations include extending the fusion to C4-5. She also awaits authorization for hand surgery with Dr. ***** and right shoulder surgery with Dr. *****. Continued follow-up pain management with Dr. ***** was recommended.

There is a Supplemental Report from Dr. ***** dated [redacted]. Dr. ***** reviewed the supplemental report of Dr. ***** dated [redacted]. Dr. ***** was asked to comment regarding right shoulder injury. Dr. ***** indicated Dr. ***** stated that if the patient only worked 4.6% of the time from [redacted] it would ben medically improbable that she sustained a continual trauma injury during that period of time involving the right shoulder. He states that it is therefore concluded that her current right shoulder problems are unrelated to her industrial exposure with the County of ***** and are secondary to events that occurred outside of her work experience. He stated that if the assumption is correct, he is going to modify his opinion

and state that there actually was no sufficient time for the patient to develop a continual trauma problem.

Dr. ***** indicated he respectfully disagreed with his opinions regarding the right shoulder. Based on my review of the medical records, this assumption by Dr. ***** completely contradicts all of the prior medical evidence regarding the patient's ongoing right shoulder problems. In a follow-up report dated [redacted] from Dr. *****, the patient presented with a 5-year history of right shoulder pain, worsened with reaching above and behind shoulder level. The report indicates she did have a traumatic event when her arm was pulled by a patient. She was diagnosed with chronic right shoulder tendinitis and she was given a corticosteroid injection. In another report dated [redacted], the patient was seen by Dr. *****. He reviewed the MRI which showed evidence of subacromial impingement, partial rotator cuff tear with tendinosis.

Dr. ***** indicated it is quite obvious that this patient has a right shoulder condition that is industrially related and due to a continuous trauma. Even if she was asymptomatic for a period of time, the worsening symptoms that she has likely experienced are not related to non-industrial factors. It is directly related to a specific condition that the patient had, which is chronic and is supported by objective findings seen on the prior MRI studies. In my opinion, all treatment for the right shoulder should be provided on an industrial basis.

There are additional Progress Reports from Dr. ***** dated from [redacted] through [redacted] The patient reported ongoing neck and right shoulder pain. On April 3, 2015, Dr. ***** requested authorization for removal of hardware from the fusion sites at C5, C6 and C7, exploration of fusion with possible revision fusion as well as extension of fusion to C4-5 consisting of an anterior cervical decompression and fusion. On [redacted], [redacted], Dr. ***** noted the insurance company denied the surgery. Dr. ***** continued to request that surgery be authorized.

On [redacted], Dr. ***** issued a Progress Report again requesting right shoulder surgery. The patient reported a dramatic increase in her right shoulder pain.

There are additional Progress Reports from Dr. ***** dated from [redacted] through [redacted]. On [redacted] Dr. ***** noted she had recent updated x-rays of the cervical spine on [redacted] which showed no acute changes. They continued to show pseudoarthrosis. Dr. ***** continued to request surgery to the neck. The longer the patient awaits authorization for the cervical spine surgery, the more risk there is she can develop permanent nerve damage. On [redacted], Dr. ***** noted that the surgery was now authorized. When seen on [redacted] she reported yesterday, she was

picking up a box of laundry detergent when she heard a pop in her right shoulder and started to have severe right shoulder pain. She says she had a lot of difficulty moving her right shoulder since yesterday. She was continued on Norco, Ibuprofen, gabapentin and Prilosec.

There is an Operative Report from ***** Surgery Center, Dr. ***** dated [redacted]

Operations performed:

1. Removal of hardware, anterior C5 through C7.
2. Exploration of fusion.
3. C4 partial corpectomy.
4. C5 partial corpectomy.
5. C4-5 anterior cervical fusion.
6. Cage placement with Phantom Plus PEEK cage.
7. Placement allograft demineralized bone matrix.
8. Instrumentation with Eminent Spine plate and screws.
9. Microdissection, spinal cord and nerve roots.

The diagnoses were:

1. Status post C5 through C7 surgery by a different surgeon at a different hospital.
2. C4-5 adjacent segment disease.
3. Spinal stenosis C4-5.
4. Osteophytes C4-5.

The patient was seen for postoperative visit by Dr. ***** on [redacted]. She is one day post-op. The patient states she went to the emergency room last night, however, left AMA due to the long wait. She states she received x-rays and an EKG while in the ER. She states she was having swallowing difficulties, shortness of breath and was coughing up blood. She states these issues have resolved. She denied any fever, chills, night sweats or active drainage from the surgical site.

The patient reported she has ongoing general orthopedic follow ups with Dr. ***** for her right shoulder and right hand. She says she continues to have severe right shoulder pain. She says that Dr. ***** is currently requesting a trigger finger release for her right

hand and right shoulder surgery. She has ongoing follow ups with her primary doctor and says she was told that her stress is causing diabetes. She last worked on [redacted].

Dr. ***** indicated she appears to be doing well. The drainage tube was removed today without complications. She should return to our clinic in two weeks to have her sutures removed. She will continue Gabapentin and Percocet.

There is another Progress Report from Dr. ***** dated [redacted]. She is seven days postop. She says that on [redacted] she went to the emergency room at St. *****'s because she was having difficulty swallowing and shortness of breath. She says they performed a blood test and said she may have a blood clot. She says she left the hospital AMA but then returned the next day. She states she had what she thinks was a CT scan, which did not show a blood clot. She says she continues to have shortness of breath. She says her neck pain has been severe and she rated her current pain at 6-9/10. The right arm symptoms have improved somewhat since surgery but her neck pain is severe. She reported ongoing and severe spasms in her neck. She had had some difficulty swallowing since the surgery. She was advised to go to the emergency room for her persistent shortness of breath. Pain management follow-up requested. She was discontinued on Percocet and will go back to the Norco. Dr. ***** indicated he was concerned about her symptoms and she was advised to follow-up next week. She was considered temporarily totally disabled while recovering from surgery.

There is another Progress Report from Dr. ***** dated [redacted]. The patient reported she is feeling better. She attributes much of this change to her medication change. She says she continues to have some swallowing difficulties, but this is improving. She is no longer having shortness of breath or coughing up blood. X-rays of the cervical spine showed the hardware at C4-5 was intact for post-op. She was continued on pain management follow-up. Request general orthopedic follow-up with Dr. ***** for the right shoulder and right hand. She was advised to continue wearing the neck brace. Follow up in four weeks. Temporary total disability while recovering from surgery.

There are numerous additional Pain Management Follow-up Reports (***** *****, M.D. and ***** *****, M.D. from ***** ***** ***** ****** dated from [redacted], [redacted]. The patient was continued on medication management.

There is a Deposition of Jane Doe taken on [redacted]. Ms. Doe indicated she is presently taking Neurontin 600 milligrams twice a day. She also takes Tramadol 50

milligrams as needed for pain and Motrin 800 milligrams a day. She was also just started on Norflex last week. She is presently not working.

Ms. Doe stated she started working for County of ***** in [redacted] but she became permanent in [redacted] She last worked for the County on [redacted] She stated Dr. ***** put her on restrictions that the County was not able to accommodate.

She is presently receiving regular retirement benefits in the amount of [redacted] per month. She started receiving these in [redacted]

She described the work-related injury on [redacted] indicating she was translating in Spanish to a client that was already given her injection and we took the restraints off her and when I was translating, she attacked me. She stated, "She just snapped, grabbed me, and took me down." She grabbed her by the hair and the staff was trying to pull her fingers out of my hair and "I was just getting yanked back and forth." She sustained injury to her neck and shoulder. She initially missed only a couple of days of work and then went back to work. She went back to her regular job duties. She continued to perform her normal job duties for about a year and then she saw a "doctor specialist" because she couldn't lift her neck off the bed. Then they finally sent her to Dr. *****, a surgeon, "so I finally had a surgery a year later." In [redacted], she had the surgery with Dr. *****.

She stated she was on disability for six months after the surgery. Her attorney for this claim was ***** *****. She did not receive any monetary settlement for this claim and there was some resolution of this claim. The surgery was a fusion of the C5-C6 and 7 where they put hardware in her neck.

She stated on [redacted] she had a second neck surgery; "they had to rejustify the hardware in there where it shifted." It was causing pain, so they put another plate and screw. They just fixed the hardware. She is still going through postoperative physical therapy for this. She stated, "my neck is still bothering me a lot in therapy, but I'm still working on it." The second surgery was done by Dr. *****.

She was asked about an injury on [redacted] and she stated that was injury to her hands and on that day her carpal tunnel was progressing. She had received therapy and it didn't resolve it and surgery was recommended to both hands. The right hand was worse than the left. She was on limited duty for her hands working as an office assistant III. She stated that Dr. ***** precluded her from patient contact so that is why she went to office assistant.

She was asked about a problem where she had disclosed medical information on a patient and the County then would not let her work with medical patient records and she stated "it came out --- the outcome of that was I didn't break the HIPAA law, so they placed her in the maintenance department as an OA III in the maintenance department. She stated that they suspended her and then moved her to another department where she didn't have patient information so she moved to the maintenance department.

She stated she had two work-related carpal tunnel surgeries, the right hand and the left. She also had a trigger finger surgery on the left hand. She denied any other work-related injuries at the County or any other surgeries. She stated that the trigger finger surgery to the left middle finger did fix the problem. She was asked if the left-hand carpal tunnel syndrome was successful and she stated, "I'm okay with it." She stated the right-hand carpal tunnel surgery made her functional, she gained "a little function." She stated "I'm still pending surgery for the right-hand trigger finger and thumb today; Dr. ***** is requesting it and he hasn't got authorization yet. She has problems with the middle finger and thumb; they lock and it's like "my whole hand is on fire."

She stated she is received postoperative physical therapy for her neck at ***** Hand Therapy and she just got authorized for another seven weeks. She stated the therapy is helping, "somewhat." It's relieving a little bit of pain and maybe more functional somewhat.

She stated that prior to the neck surgery she wasn't able to hold her neck up for so long and she had to lay down most of the time. She stated, "As long as I take my medicine, I can function a little bit and pick up things here and there, but I have.to lay down again, because my neck is just throbbing pain."

She stated "I have my right shoulder surgery that is pending for authorization that was the same injury on [redacted]." The doctor told her yesterday that the surgery was rejected again. She stated that she can't lift her right shoulder up for as long and she is having throbbing pain. She stated, "I have spasm and it's not functional." Dr. ***** is treating her for her right shoulder. She has a problem putting her right arm over her head and she can't lift anything or hold anything in her hand; "it's throbbing pain all day long" in her right shoulder. She has been having problems with her right shoulder for one or two years now. She stated the orthopedic doctor was going to authorize surgery and then he reported to my insurance that it was work-related and workers' compensation took over, and workers' compensation is denying it.

She stated her worst pain is in the neck. She has difficulty lifting laundry and washing dishes and she can only do so much and then she has to rest, because the neck is a throbbing pain hitting 24/7. The second biggest problem is the right shoulder pain and then her pain that goes from her shoulder to her right thumb and trigger finger, “it’s like it’s on fire and it gets numb pretty bad.” She stated that she can’t concentrate and focus because of the pain level.

She stated she can sit for roughly 20 minutes before she needs to change positions. It was noted that she had been sitting her continuously for 42 minutes but she indicated, “I took medication, I’m tolerating it.” She can stand and walk for about 15 to 20 minutes. She can’t run because she has a bad knee. She estimated she can lift about five pounds. She was asked about keyboarding and she stated “I’m actually not able to use my hands”, so she doesn’t feel she could do keyboarding and actually the County is supposed to accommodate me with an “ergonomical keyboard thing.” She also can’t concentrate so doesn’t feel she could do any keyboarding. She cannot push and pull objects.

She discussed nonwork-related surgeries and problems including three left knee surgeries. She had a total knee replacement. She was asked how her left knee is doing now and she stated, “Okay, I can jump up and down, I can walk normal.” Before she was walking with limp.

She discussed the incident where her sister hit her with a metal bar in the back and the neck. She stated, “I ended up in the emergency room.” She believes this was in [redacted] She hit her in the upper back and the neck area, twice. She stated she owed me money and she didn’t want to pay me.” She stated “I was able to go to work the next day and they seen the bruises on my back and that was about it and I recovered.”

She also discussed being assaulted by her husband; he broke her thumb, “so he was in jail at the time and I feared for my life at one point, but I recovered from that.” She denied any other injuries as a result of her husband attacking her. She divorced him.

She stated that when they were trying to evaluate her for the HIPAA law, they were going to suspend her with pay and that day she went home and the whole side of her face dropped and she went to the emergency room and she was kept overnight for CAT scan. They told her if it comes back normal, you had a mini stroke; if it comes back abnormal, the job caused it. She stated, “Which it came to the stress of her job caused that.” They concluded that she didn’t have a mini stroke; it was stress.

She denied any other nonindustrial injuries including automobile accidents, slip and falls or anything where she got injured.

She reported an earlier workers' compensation injury when she was giving a patient medication and he actually broke her wrist and she was placed in a cast for a while. She was working for ***** ***** ***** at the time. She stated she made a full recovery from this injury. She was represented by ***** ***** and had a workers' compensation case.

She stated she was off work from [redacted] because the County could not accommodate her. When she returned to work, she was in the maintenance department doing file clerk work.

She was asked about a return to work offer she was made by the County on [redacted]. It was noted she failed to attend a return to work meeting in April or May [redacted] and she stated, "That never happened, I never got the paperwork." She was asked about another meeting that she failed to attend in [redacted] when the county was trying to get her back to work and she stated that there was a dispute regarding her work restrictions.

She was asked about a conversation with the County around [redacted] when they asked her to report to work and she told them she was volunteering at the Cowboys training camp and was not available to come in to work. She stated that never happened. She did admit that she has been volunteering at the Cowboys training camp for the past ten years so she always takes her sick time or vacation hours to work it. She admitted that she did work at the Cowboys training camp in [redacted] but stated, "I was only able to do a few hours there because I wasn't able to do it. She stated, "I worked one two-hour practice session only once a week and I only worked three practice sessions in total or a total of six hours. She stated that she was stationed outside the VIP area and when people would come up to her, she would determine whether they had the proper credentials to get into the VIP area and if they didn't, she would direct them to another area. She stated she was able to stand, sit or lay down, because they were able to work with her because she could only do so much.

She stated that she was contacted by the County to come back to work with the restrictions given by Dr. ***** because they were able to accommodate her with the restrictions given by Dr. *****, but she said she couldn't because her attorney advised her not to. She stated she did not agree with the restrictions of Dr. *****, because they weren't the same as Dr. *****'s restrictions. It was agreed to continue the deposition at a later date.

There is a Second Agreed Medical Examination Report from ***** *****, M.D. The patient was evaluated on [redacted] This evaluation concerned an alleged instant industrial injury, which occurred on [redacted]; a continuous trauma / occupational injury on [redacted] and an alleged continuous trauma occupational injury on [redacted] – [redacted] Numerous prior medical records were reviewed.

The patient is a [redacted]-year-old female who sustained multiple orthopedic injuries, while performing her usual and customary job duties as a health technician III/Office assistant II for the County of ***** from [redacted] through her last day of employment on [redacted] She sustained work related specific injuries in [redacted] and again in [redacted] wherein she was attacked by a patient, injuring her neck and right shoulder. She recalls that she underwent care and treatment for several weeks to months and continued working full duty. She indicates that over the next year or so, she began to experience progressively increasing neck pain. She underwent a course of physical therapy, was prescribed medications, underwent cervical epidural blocks, performed home exercises, but nonetheless her neck pain continued to escalate.

The patient underwent a two-level anterior cervical discectomy and fusion and physical therapy, which did help to diminish her neck symptoms. However, she still remained with right shoulder pain and difficulties.

The patient was eventually returned to work with restrictions. Based on those restrictions, she could no longer perform the normal work duties required of a Health Tech III. Therefore, in [redacted], she was promoted to office assistant III so that she could continue working full time. Her new work duties required prolonged repetitive bilateral upper extremity tasks and after several years of performing these tasks, she began to experience bilateral wrist and hand pain as well as increasing right shoulder pain. She was referred for treatment and was informed she had carpal tunnel syndrome bilaterally. She was also experiencing triggering of the middle fingers of both hands.

The patient underwent a right carpal tunnel decompression with Dr. ***** in [redacted] She attempted return to work but had difficulty and so she missed a great deal of time from her normal work hours. This was primarily because of her left hand and wrist as well as her right shoulder symptoms. She also began to experience escalating recurrent neck pain, despite her missed work days. She again underwent surgery with Dr. ***** in [redacted] in the form of a left carpal tunnel decompression. She also underwent an A-1 tunnel release of the left middle finger trigger digit.

The patient was seen by Dr. ***** for her neck symptoms and underwent a second cervical spine surgery toward the end of [redacted] followed by a course of postoperative physical therapy. Although this did help to diminish her neck symptoms, she still remained with neck pain.

Dr. ***** indicated the patient indicates she officially retired in [redacted] but was still symptomatic with regard to her right shoulder, and right wrist/hand symptoms. She saw Dr. ***** for her right shoulder symptoms and underwent surgery in the form of right shoulder arthroscopy and decompression in [redacted] She saw Dr. ***** for her right wrist and hand symptoms and underwent a right middle digit A-1 tunnel release on [redacted]

Dr. ***** indicated she was seen by him for initial AME on [redacted] At that time, she still remained treating for her postoperative shoulder with Dr. ***** and with Dr. ***** for her postoperative right wrist and hand.

Dr. ***** indicated at the time of initial AME on [redacted] I declared her as having reached maximal medical improvement with regard to her cervical spine and left wrist/hand injury and procedures performed.

Dr. ***** indicated with respect to her recent right shoulder/right upper extremity surgical procedures and postoperative therapeutic intervention currently underway, I provided an opinion that she remained temporarily totally disabled.

On today's evaluation, she completed her course of right shoulder postoperative physical therapy, as well as her postoperative right middle digit. She has continued to perform home exercise program. Presently, she indicates she is doing well and has recently been discharged from treatment.

For her present right shoulder symptoms, she has experienced significant improvement with regard to her right shoulder. She only has pain if she uses her right upper extremity for too long a period of time or with overhead reaching. She denied any popping of her shoulder with motion, or swelling. She denied any numbness and tingling of her right upper extremity

Dr. ***** indicated she denied any history of injury, symptoms or need for medical care and treatment with regard to her right shoulder, prior to the onset of her current occupationally related symptoms. She still experiences minimal discomfort with regard to her right hand. She denied any swelling in the right wrist or hand. She reported rare to

non-existent clicking of her right middle digit with use. She states that range of motion of all the digits of her right hand is normal. She does have slight loss of grip strength but primarily secondary to discomfort with full grip force. She denied any further numbness and tingling of her right wrist/hand.

Past medical history: Work-related injury left wrist on [redacted] which required a period of casting, rest and work restrictions. She was diagnosed with traumatic extensor tendinitis, left wrist and forearm. She was returned to full work duties by Dr. *****. It is unclear what specific permanent disability rating or award may have been provided. The patient specifically denied any history of injury, symptoms or need for medical care and treatment with regard to her right wrist or hand prior to the onset of her current occupational symptoms.

Dr. ***** noted she sustained a specific occupational injury to her neck/upper trapezius on [redacted] for which she was provided with an 11% disability settled by stipulation. Additionally, she sustained a second specific injury to her neck on [redacted], [redacted] which settled for 1% disability via stipulation. She also reported having sustained multiple work-related needle stick injuries. She reported having undergone two left knee arthroscopic surgeries and a left total knee replacement in [redacted]. She has a history of type II diabetes mellitus (diagnosed approximately 12 years ago). She admits she is not taking any medication for her diabetes. She also has history of hypertension and hypercholesterolemia. She had an ocular stroke on [redacted]

Dr. ***** indicated she is presently not working. She last worked for the County of ***** on [redacted] and officially retired in [redacted]

Examination of the right shoulder revealed well-healed arthroscopic portal scars. The general shoulder contours were equal bilaterally. There was no swelling, atrophy, asymmetry or ecchymosis present. There was slight tenderness elicited to palpation over the biceps tendon, in the region of the intertubercular groove. There was no spasm of the right shoulder girdle musculature appreciated. Range of motion: Abduction 150 degrees on the right and 170 degrees on the left, adduction 30 degrees on the right and 40 degrees on the left, extension 40 degrees on the right and 50 degrees on the left, flexion 160 degrees on the right and 180 degrees on the left, internal rotation 30 degrees on the right and 80 degrees on the left, external rotation 70 degrees on the right and 90 degrees on the left. Motor strength normal bilaterally. Deep tendon reflexes 1+ bilaterally in biceps, triceps and brachioradialis. Girth measurements: Brachium 11-1/4” on the right and 11” on the left and forearm 9-1/4” on the right and 9” on the left. Sensation normal in all upper extremity dermatomes. Two-point discrimination was 6 millimeters in all digits.

Apprehension sign negative. Glenohumeral joint stability stable to inferior, anterior and posterior stresses. Impingement test I and II slightly positive. Humeral relocation test negative. Drop arm test negative for rotator cuff injury. Yergason's test negative for long head of biceps tendon instability. Hoffman sign negative.

Examination of the right wrist/hand revealed a 5 cm well-healed Chevron-type scar situated over the palm and distal forearm volarly. This was well-healed. There was also a 2 cm transverse, well-healed scar over the distal palmar crease, just below the middle digit. There was no evidence of allodynia, hyperpathia or sudomotor activity. No hair / nail-plate changes, etc. There was minimal tenderness elicited to palpation over the surgical scar region. Wrist range of motion was ulnar deviation 30 degrees on the right and 20 degrees on the left, radial deviation 20 degrees on the right and 10 degrees on the left, extension 60 degrees on the right and 45 degrees on the left, flexion 60 degrees on the right and 40 degrees on the left, pronation 80 degrees bilaterally and supination 80 degrees on the right and 30 degrees on the left. Thumb: Palmar abduction 70 degrees and palmar adduction tip misses the head of the 5th metacarpal by 1 cm, right. Tip touches the head of the 5th metacarpal on the left. Flexion/extension: Normal bilaterally. Fingers normal bilaterally. Tips of all fingers touch the palm. Motor function normal bilaterally. Grip was 45/40/45 on the right and 60/60/55 on the left. She appeared to give her best effort with grip strength. Tinel's test negative, Phalen's test negative, Finkelstein's test negative, Watson's test negative, Grind test, CMC joint thumb negative, piano key sign negative and Durkan's compression test negative. Two-point discrimination was 6 millimeters in all digits. There were no signs of vaso-motor instability. Pulses were 2+ bilaterally in radial artery.

Dr. ***** reviewed prior medical records as well as x-rays and other diagnostic studies.

Dr. *****'s impressions were as follows:

1. Continuous trauma / occupational injury [redacted] resulting in

    A. Aggravation of adjacent segment disease with retrolisthesis, C4-5 spinal segment (CT scan [redacted].
    B. Aggravation of symptomatic impingement syndrome and rim rent tear, supraspinatus portion of rotator cuff, right shoulder.
    C. Aggravation of trigger finger, middle digit, right hand.
    D. Status post left middle finger A-1 tunnel release (2013-no operative report available to this evaluator).

E. Status post left carpal tunnel decompression ([redacted] – no operative report available to this evaluator)
F. Development of symptomatic adjacent segment disease (ASD), C4-5 with retrolisthesis (CT scan [redacted]).
G. Status post revision cervical spine surgery with removal of hardware and extension of fusion to include C4-5 spinal segment ([redacted] – no operative report available to this evaluator).
H. Status post right shoulder arthroscopy, decompression and Mumford procedure ([redacted] – no operative report available to this evaluator).
I. Status post right long trigger finger release and flexor tenosynovectomy ([redacted].

2. Continuous trauma / occupational injury [redacted] resulting in:

A. Aggravation of previous symptomatic cervical discogenic spondylosis.
B. C7 root irritation (EMG/MCV [redacted].
C. Carpal tunnel syndrome, bilateral wrists.
D. Trigger fingers, middle digits, bilateral hands.
E. Right shoulder impingement syndrome with rim rent tear, supraspinatus portion of rotator cuff (MRI [redacted]).
F. Status-post C5-6/C6-7 anterior cervical discectomy and fusion ([redacted] – no surgical report available to this evaluator).
G. Status post right carpal tunnel decompression ([redacted] – no operative report available to this evaluator).

3. Prior specific work-related injury of [redacted] as follows:

A. Cervical myoligamentous sprain/strain.
B. Aggravation of cervical discogenic pain.

4. Prior specific work-related injury [redacted], resulting in:

A. Cervical myoligamentous sprain/strain.
B. Trapezial strain.
C. Instigation of cervical discogenic pain.

5. Status-post specific work comp injury [redacted] as follows:

A. Traumatic extensor tendinitis, left wrist/forearm.

6. Non-occupational, underlying orthopedic regional abnormalities as follows:

   A. Degenerative spondylosis cervical spine (MRI [redacted]).
   B. Assault injury with cervical spine contusion – sprain/strain ([redacted]).
   C. Degenerative AC joint osteoarthritis, right shoulder (MRI [redacted]).

Dr. ***** discussed causation as follows:

1. Continuous trauma [redacted] although I do not agree that there is a CT injury [redacted] It is this evaluator's opinion that there is a new continuous trauma injury [redacted] She did sustain a prior continuous trauma injury [redacted] involving her neck, right shoulder and bilateral wrists/hands. Based on her progressively increasing symptoms with regard to her cervical spine, right shoulder and bilateral wrists/hands, after returning to work from [redacted] despite the time missed from work; the extended period of time required for appropriate authorization of the surgical procedures, the operative surgeries performed, it is this examiner's opinion that the preponderance of medical evidence does support the existence of a recent continuous trauma injury [redacted]

2. Continuous trauma / occupational injury [redacted] – the mechanism of cervical spine, right shoulder and bilateral wrist/hand injury is consistent with her subjective complaints, the objective physical examination findings, the specific history of symptom instigation, her temporal report of complaints, substantiation of her injury / complaints within the body of the medical records and supported by diagnostic studies. It is this examiner's opinion that there is a causal relationship between her continuous trauma / occupational injury claim [redacted] and her cervical spine, right shoulder and bilateral upper extremity injury symptoms.

3. Specific injury [redacted] – the mechanism of this patient's alleged instant occupational injury [redacted] is not consistent with her subjective complaints, the objective physical examination findings, the specific history of symptom instigation, this patient's temporal report of complaints or substantiation within the body of the medical records. She does admit to sustaining a specific injury involving her neck and trapezius/right shoulder on [redacted] She does not indicate any specific injurious event after [redacted] All of her orthopedic regional injuries suffered and sustained thereafter were on a continuous trauma

basis. The preponderance of the medical evidence does not support the existence of a specific injurious event having been sustained on [redacted].

Dr. ***** indicated she was declared permanent and stationary with regard to her cervical spine and left wrist/hand and my opinions in this regard remain unchanged. She has reached maximal medical improvement with regard to her right shoulder and right wrist/hand.

Dr. ***** indicated she has 28% whole person impairment for the cervical spine for a DRE cervical category IV impairment of the whole person, because she had loss of motion segment due to a successful attempt at surgical arthrodesis. She has undergone a three-level cervical spine fusion, C4-5, C5-6 and C6-7. Total combined right upper extremity impairment is 16% whole person impairment. Total combined left upper extremity impairment is 20%. She was given 3% whole person impairment rating increase for pain disorders. Final total whole person impairment rating = 57%.

Dr. ***** indicated she has a permanent impairment precluding lifting in excess of 15 to 20 pounds, pushing/pulling in excess of 25 pounds on wheels and performing activities requiring motions of her neck for the cervical spine. For the left wrist/hand she is precluded from forceful gripping/grasping not to exceed 20 inch / pounds of torque / grip force and limiting her to occasional repetitive tasks with her left upper extremity. For the right shoulder, she is precluded from lifting over 15 to 20 pounds from floor to chest level and more than 10 pounds above shoulder level. She is precluded from prolonged overhead use of her right upper extremity. For the right hand she is precluded from forceful gripping/grasping (contemplated not to exceed 20 inch / pounds of torque / grip force) and limited to occasional repetitive tasks with her right upper extremity.

Dr. ***** recommended that she continue her home exercise program and use of non-steroidal anti-inflammatory medication if necessary, for pain relief. Future authorization should remain open for diagnostic studies, occasional access to medical care for orthopedic surgical follow-ups, pain management evaluation and appropriate pharmacologic intervention. Hardware removal should also be authorized should her symptoms escalate or she develops signs of myelopathy.

Dr ***** indicated she indicated she has been retired since [redacted]. She therefore, does not meet the criterion for inclusion within the voucher program.

Dr. ***** apportioned 25% of her permanent impairment for the cervical spine to continuous trauma. / industrial injury [redacted] approximately 50% to

continuous trauma / occupational injury [redacted] approximately 5% to the specific work injury of [redacted] 15% to the occupational injury of [redacted] and 5% to the natural progression of non-occupational degenerative cervical spondylosis. 30% of her impairment for the left wrist/hand was apportioned to continuous trauma [redacted] through [redacted] 60% to continuous trauma [redacted] and 10% to the natural progression of her median nerve neuropathy and tendinitis resulting from her underlying non-occupational adult onset diabetes mellitus and obesity. 30% of her right-hand impairment is apportioned to continuous trauma [redacted] 60% is due to continuous trauma from [redacted] and 10% is non-industrial. For the right shoulder, 40% is apportioned to continuous trauma [redacted] 50% to continuous trauma [redacted] and 10% is non-occupational degenerative AC osteoarthropathy.

DIAGNOSES:

1. Status post re-do ACDF at C4-5 with a plate, screws and a cage.

2. Status post right shoulder arthroscopic decompression, including Mumford procedure.

3. Status post left middle trigger finger release.

4. Status post right long trigger finger release.

5. Status post right open carpal tunnel decompression.

6. Status post left endoscopic carpal tunnel decompression.

SUMMARY OF FINDINGS:

Ms. Doe presents for evaluation of complaints involving her neck, right shoulder and bilateral wrists/hands that she attributes to her employment with the County of *****.

She states she began her employment with the County of ***** on [redacted] as a health technician III.

She describes her work activities as having worked in a locked mental health facility, checking on patients in the morning, giving patients a shower and distributing meals and

snacks. She states that she would take a history and obtain vital signs, and would also transport patients utilizing a van to other facilities, hospital emergency rooms, and doctor's appointments. She states that some patients were combative, assaultive, and she had to restrain them, and sometimes had to quickly administer medication to calm them down. She mentions that she assisted nurses in restraining patients. She states that she translated for physicians, ordered supplies and snacks and stocked them, and entered information about every activity of each patient every day. She mentions that she spent approximately 2-4 hours a day typing, and approximately 1-2 hours per day writing each day.

She has described the physical requirements of her job as including prolonged neck flexion, pushing and pulling heavy parts, overhead reaching, and repetitive arm and hand movements, including reaching, and simple and forceful grasping as well as lifting and carrying over 50 pounds.

According to her history, she last worked for the County of ***** on [redacted] when she was placed on modified duty. She states her employer cannot accommodate her modified duty and she has not worked since then.

She states that she was at work on [redacted] translating for a patient when she was attacked and pulled down to the ground, and experienced pain in her neck and right shoulder. She states that after that incident she went to the hospital emergency room and was off work for a period of time.

Ms. Doe describes having seen a physician, had an MRI scan of her neck and subsequently underwent cervical spine surgery sometime between [redacted] She states she received post-operative physical therapy and experienced decreased pain in her neck. She states that as time went on the pain increased.

She states she does not recall how long she was off work at that time.

Ms. Doe does note that at one point an ergonomic evaluation of her work station was completed but most of the recommendations for the changes were not implemented.

Ms. Doe states she developed pain in her right wrist and hand, with numbness and tingling, which she attributes to opening heavy doors continually, taking down patients, picking up and moving heavy charts and picking up and moving heavy boxes. She states that her primary care physician placed her on modified duties with restrictions, including

no patient contact, which the employer was unable to accommodate and she was off work for nearly a year.

She states she became an office assistant III in [redacted], and was moved to various departments, including working in the x-ray/ultrasound department in the alcohol/drug program, maintenance department, and in the financial/administration building as a biller. She states that her symptoms increased during this time due to repetitive movement. Ms. Doe states she subsequently came under the care of another physician who treated her with physical therapy for her neck and right shoulder, and she was administered injections. She states that she had relief of symptoms for approximately one month each time and then the pain returned to the same level.

Ms. Doe reports having had an MRI of her right shoulder and was told she needed surgery. She mentions the right shoulder surgery was eventually authorized, and was performed around [redacted]

She also reports having had left and right carpal tunnel surgery. She states she was given work restrictions of no working more than two hours a day. She states that after a week she was unable to continue because she was unable to sit for two hours, and because she was unable to use her right hand to perform duties.

Ms. Doe states she underwent cervical spine surgery in [redacted] and had post-operative physical therapy. She states she was unable to return to work because her restrictions could not be accommodated.

On review of the available records, an Application for Adjudication of Claim dated [redacted] notes she was claiming injury on [redacted] to the wrist/hand, described as having developed carpal tunnel syndrome due to excessive use of her hand and wrist.

An Agreed Medical Examiner's Report by Dr. ***** dated [redacted] notes the dates of injury were [redacted] and continual trauma. It was noted that her upper extremity problems were due to continual trauma from [redacted] and she was not permanent and stationary. At that time it was noted that she was going to need work restrictions of no very repetitive grasping, pinching, holding, twisting, torquing or flexion/extension, and no activities requiring very repetitive fine finger manipulation or finger dexterity which was a 25% loss of the preexisting, bilaterally. It was also noted she would need an ergonomically correct workstation.

Another Agreed Medical Examiner's Report by Dr. ***** dated [redacted] mentions she returned to work in [redacted] with restrictions, after having undergone a right carpal tunnel release on [redacted] It was mentioned that she was injured by a patient at work and was seen at the ***** County Health Care on [redacted] for her right shoulder and was diagnosed with tendonitis and rotator cuff tear. It was mentioned that she was going to need a restriction, if the right shoulder was due to an injury, of no repetitive heavy work overhead and no very heavy lifting or carrying. It was noted that for the continual trauma she would need a restriction of no very repetitive forceful pushing or pulling, gripping, grasping, pinching, holding, twisting, torquing or flexion/extension with a similar magnitude, and she had loss of her preinjury capacity for fine finger manipulation or finger dexterity, estimated to be 17%.

A supplemental Agreed Medical Examiner report by Dr. ***** dated [redacted] notes she only worked for 4.6% of the time from [redacted] and it would be medically improbable that she sustained a continual trauma injury during that period of time. It was also noted that it was medically improbable that anyone that is going to develop rotator cuff tendonosis or impingement or tenosynovitis with that amount of hand activities, especially if she was only working four hours per day, during that short period of time.

A second Agreed Medical Examination Report by Dr. ***** dated [redacted] is reviewed. The first AME report by Dr. ***** is unavailable for review. Impressions were listed for the cervical spine, right shoulder, and bilateral wrists/hands. It was noted that she had been declared to have reached maximum medical improvement with regards to her cervical spine and left wrist/hand at the time of the initial AME on [redacted] and the AME's opinions remained unchanged. She presented on [redacted] after completing a course of right shoulder post-operative physical therapy as well as her post-operative A-1 tunnel release, right middle digit. She was noted to have reached maximum medical improvement with regards to the right shoulder and right wrist/hand. Impairment was addressed.

The Agreed Medical Examiner on [redacted] recommended work modification/preclusions that included:

For the cervical spine, she was restricted from lifting in excess of 15-20 pounds, pushing/pulling in excess of 25 pounds on wheels, and precluded from performing activities requiring repetitive motions of her neck.

Regarding the left wrist/hand, she is restricted from forceful gripping/grasping activities, contemplated not to exceed 20 inch/pounds of torque/grip force, and limiting her to occasional repetitive tasks with her left upper extremity.

For the right shoulder, she is precluded from lifting in excess of 15-20 pounds from floor to chest level, precluded from lifting more than 10 pounds above shoulder level, and precluded from prolonged overhead use of her right upper extremity.

Referable to the right wrist/hand, she is precluded from forceful gripping/grasping activities, contemplated not to exceed 20 inch/pounds of torque/grip force, and limiting her to occasional repetitive tasks with her right upper extremity.

NECK:

She complains of frequent neck pain that radiates to the right shoulder, with intermittent numbness and tingling in the right arm.

Examination of the cervical spine reveals a healed anterior cervical discectomy incision on the left side at approximately the C6 level that is non-tender to palpation. There is tenderness to palpation of the left trapezius muscle, with some muscle spasm. Range of motion of the cervical spine is slightly restricted. Motor, sensory and reflex examinations of the cervical dermatomes and myotomes are normal.

Current x-rays of the cervical spine reveal a C4-5 anterior fusion with a cage and a plate with screws in the body of C4 and C5. There is straightening of the cervical lordosis.

The findings are supportive of status post re-do anterior cervical discectomy and fusion at C4-5 with a plate, screws and a cage.

Referable to the cervical spine she is restricted from lifting greater than 20 pounds, pushing/pulling greater than 25 pounds on wheels, and repetitive neck movements greater than 30 minutes per hour throughout an eight hour work day.

RIGHT SHOULDER:

She complains of right shoulder pain, frequently, that extends into the right shoulder blade area.

Examination of the right shoulder reveals multiple healed arthroscopic incisions. There is diffuse tenderness to palpation of the right deltoid. Impingement signs are negative at the right shoulder. Range of motion of the right shoulder is slightly restricted.

Current x-rays of the right shoulder show there has been a Mumford procedure, within an oblique osteotomy of the distal clavicle.

The findings are supportive of status post right shoulder arthroscopic decompression, including Mumford.

For the right shoulder she is restricted from lifting greater than 20 pounds from floor to chest level, lifting greater than 10 pounds above shoulder level, and prolonged overhead use of the right upper extremity of greater than 45 minutes per hour, throughout an eight hour work day.

RIGHT WRIST/HAND:

She complains of infrequent pain in the right wrist and hand. She denies pain in her right thumb and four fingers of the right hand. She also notes intermittent weakness in her right hand.

Examination of the right wrist/hand reveals a healed carpal tunnel incision on the right wrist. Tinel's sign is negative over the carpal tunnel and Phalen's test is negative. There is no triggering of the fingers of the right hand, which have full range of motion. Sensation is normal in the median nerve distribution, as well as the radial and ulnar nerve distributions. There is no intrinsic muscle atrophy of the right hand. Range of motion of the right wrist is slightly restricted.

Current x-rays of the right wrist/hand are normal.

The findings are supportive of status post right open carpal tunnel decompression, and status post right long trigger finger release.

For the right wrist/hand, she is restricted from forceful gripping, grasping and torquing (no firm holding or applying squeezing pressure with the hand to objects weighing greater than 20 pounds, or exceeding 20 inch pounds of applied pressure with the hand), and restricted from repetitive fine manipulation, including typing, keyboarding or writing, utilizing the right hand and fingers for longer than 30 minutes per hour, throughout an eight hour work day.

LEFT WRIST/HAND:

She currently has no complaints in the left wrist/hand.

Examination of the left wrist/hand reveals a barely perceptible endoscopic type healed incision of the left wrist. Tinel's sign is negative over the carpal tunnel and Phalen's test is negative. There is no triggering of the fingers of the left hand, which have full range of motion. Sensation is normal in the median nerve distribution, as well as in the ulnar and radial nerve distributions. There is no intrinsic muscle atrophy in the left hand. Range of motion of the left wrist is slightly restricted.

Current x-rays of the left wrist/hand are normal.

The objective findings are supportive of status post left endoscopic carpal tunnel decompression, and status post left middle trigger finger release.

For the left wrist/hand, she is restricted from forceful gripping, grasping and torquing (no firm holding or applying squeezing pressure with the hand to objects weighing greater than 20 pounds, or exceeding 20 inch pounds of applied pressure with the hand), and restricted from repetitive fine manipulation, including typing, keyboarding or writing, utilizing the left hand and fingers for longer than 30 minutes per hour, throughout an eight hour work day.

COMMENT:

Based on the information available to me, Ms. Doe sustained industrial injury to her cervical spine, right shoulder, bilateral wrists/hands, left middle finger and right long finger as a result of her employment with the County of *****.

As a result of the industrial injury to her cervical spine, right shoulder, bilateral wrists/hands, left middle finger and right long finger she required treatment, on an industrial basis, including multiple surgical procedures, with residual limitations and decreased level of functioning.

On review of the Agreed Medical Examiner's report dated [redacted] I am generally in agreement with the limitations, and the restrictions are more accurately clarified as follows:

Referable to the cervical spine she is restricted from lifting greater than 20 pounds, pushing/pulling greater than 25 pounds on wheels, and repetitive neck movements greater than 30 minutes per hour, throughout an eight hour work day.

For the right shoulder she is restricted from lifting greater than 20 pounds from floor to chest level, lifting greater than 10 pounds above shoulder level, and prolonged overhead use of the right upper extremity of greater than 45 minutes per hour, throughout an eight hour work day.

For the right wrist/hand, she is restricted from forceful gripping, grasping and torquing (no firm holding or applying squeezing pressure with the hand to objects weighing greater than 20 pounds, or exceeding 20 inch pounds of applied pressure with the hand), and restricted from repetitive fine manipulation, including typing, keyboarding or writing, utilizing the right hand and fingers for longer than 30 minutes per hour, throughout an eight hour work day.

For the left wrist/hand, she is restricted from forceful gripping, grasping and torquing (no firm holding or applying squeezing pressure with the hand to objects weighing greater than 20 pounds, or exceeding 20 inch pounds of applied pressure with the hand), and restricted from repetitive fine manipulation, including typing, keyboarding or writing, utilizing the left hand and fingers for longer than 30 minutes per hour, throughout an eight hour work day.

My opinions, as noted above, are stated with reasonable medical probability.

Should any additional questions arise, I would be happy to provide answers in a supplemental report.

If you have any further questions regarding this patient, please do not hesitate to contact me.

Sincerely,

Jane Doe
[redacted]

Richard C. Rosenberg, M.D.

[redacted]

[redacted]

ADDRESS

RE: John Doe
EMP: County of *****
PT FILE #: *****
D / E: [redacted]
CASE #: *****

Dear M*. ******:

The above-captioned patient is a [redacted]-year-old, ambidextrous male who was seen in my office on [redacted] for an orthopedic evaluation of injuries which he associates with activities that occurred at work.

EMPLOYMENT HISTORY:

Mr. Doe began his employment with ***** County [redacted] Department on [redacted] as a Fire Fighter Trainee. He worked this position from [redacted]

His job duties included fire protection: fire fighting brush fires, oil fires, rubbish fires, car fires, structure fires and any other type of fires. He also did rescue methods: repelling over the side, traffic accidents, injuries, fall victims, anything involving human rescuing.

When fighting brush fires, the required uniform and equipment that he wore (wild land safety gear) weighed up (helmet, boots, hose pack on back) to 70 pounds or more.

The physical requirements consisted prolonged sitting, prolonged standing and prolonged walking in heavy, required boots. He did bending at the knees and waist, twisting and turning at the waist, stooping, squatting and kneeling. He climbed ladders, stairs, hills and mountains. He did prolonged neck flexion. He did pushing, pulling, overhead reaching, repetitive arm and hand movement, including reaching, and simple and forceful

grasping and gripping. He lifted and carried a maximum of 800 pounds and an average of 60-80 in non emergency work.

He worked 24 hours per day, 3-4 days per week. He did work overtime. He worked frequent emergency overtime.

From [redacted] Mr. Doe became a Fire Fighter. This came with more responsibility but entailed the same job duties as Firefighter trainee. He worked on a 2-person rescue squad which entailed victim extraction from vehicles or from drainage tubes. He also worked on fire ventilation which consisted of using chain saws and rotary saws and other heavy equipment.

Repetitive movements for this job position consisted of prolonged sitting, prolonged standing and prolonged walking in heavy, required boots. He did bending at the knees and waist, twisting and turning at the waist, stooping, squatting and kneeling. He climbed ladders, stairs, hills and mountains. He did prolonged neck flexion. He did pushing, pulling, overhead reaching, repetitive arm and hand movement, including reaching, and simple and forceful grasping and gripping. He lifted and carried a maximum of 800 pounds and an average of 60-80 in non emergency work.

He also worked ladder truck same duties but with more people, had to climb a max of 90 foot ladders. Anything above 22 feet is an extension ladder that is used with a rope. All this is done while wearing personal protective uniform which weighs as much as 70 lbs. when wet. Ladders can weigh up 180 pounds. He also handled 1- 4 inch hoses which the heaviest can weigh up to 50-60 pounds when dry.

Mr. Doe became an Engineer [redacted] Job duties included: prolonged sitting, prolonged standing and prolonged walking in heavy, required boots. He did bending at the knees and waist, twisting and turning at the waist, stooping, squatting and kneeling. He climbed ladders, stairs, hills and mountains. He did prolonged neck flexion. He did pushing, pulling, overhead reaching, repetitive arm and hand movement, including reaching, and simple and forceful grasping and gripping. He lifted and carried a maximum of 800 pounds and an average of 60-80 in non emergency work.

He was responsible for assigned equipment that ranged from engines, to reissued engines but worked on other equipment i.e. water tender truck, brush engine, ladder truck and patrol units. He was in charge of maintaining equipment in an emergency readiness mode. This consisted of prolonged sitting, lifting, climbing, hiking, carrying and lifting.

This consisted of repetitive climbing up and down from the fire engines and repetitive bending, squatting, turning and twisting of the back.

He states that he last worked for this employer on [redacted] On that day, he retired and is currently receiving retirement.

SUBSEQUENT EMPLOYMENT:

Fire fighter safety officer on Movie sets (multiple studio/production companies) from [redacted] This consisted of prolonged standing and walking. He states that he quit working there by choice.

HISTORY OF INJURY:

Mr. Doe states that he began having pain in his back around [redacted] He attributed it to lifting; he does not recall but thinks that it was a patient. This was due to constant lifting, pulling, carrying, bending and squatting.

He was seen for this injury but does not recall what treatment he received but the pain/injury was ongoing.

In mid 80's he injured his right knee when he stepped into a hole while fighting a brush fire. An MRI was taken and he was told that he had a torn meniscus. He had surgery for his knee around this time and took approximately 2 weeks off. He thinks he did approximately 2 weeks of physical therapy.

He states that he recovered from this injury but he reinjured approximately 3 years later (not certain on exact year) by tearing it again. This occurred when he stepped off a curb while fighting a structure fire at night.

He received another MRI and was told that he re-tore his meniscus. Dr. ***** performed his second surgery to his right knee. He thinks that he was off of work for approximately three weeks to one month. He participated in physical therapy again and he states that he recovered from this injury.

Mr. Doe injured his thoracic and lumbar spine in [redacted] due to lifting a patient.

X-ray and MRI were taken but he does not recall the outcome. He thinks he was given pain medication and also received chiropractic treatment for approximately 6 sessions which did benefit him.

In [redacted] he strained his lower back when lifting a patient from a toilet to a gurney. He does not recall the treatment that he received or time that he missed from work.

In [redacted] he injured his right shin when stepping off of a fire engine. He recalls being off of work for approximately 2 weeks. He does not recall the treatment that he received from this. He was able to return to work but states that his injury did not resolve.

In [redacted] he injured his lower back when trying to hold up a 300 pound male that had fainted. He was off of work for approximately 2 weeks but does not recall the treatment he received.

In [redacted] he strained his left hamstring due to pulling 3 inch supply hose for a structure fire. He believes that he received therapy and he was off for about a month. He states that he still has scar tissue from this injury and that it has never resolved. X-ray was taken and he was told that there was a small tear in his hamstring.

In [redacted] he tripped and fell against a door jamb and injured his mid back under his shoulder blade. He reported the injury and continued to work.

In [redacted] he reached over to grab an object and felt a pop in his right rib-cage. He went to ***** ***** hospital but does not recall the treatment that he received.

In [redacted] he was using bolt cutters and heard a pop in his left rib-cage. This injury was reported but no treatment was received.

In Marc[redacted] he injured his left hip when pulling hose during a structure fire; he reported this but did not receive any treatment.

[redacted] he injured his right side of his lower back when lifting a 300+ pound male from his bed and down a staircase. He reported this injury but did not receive any treatment. He states that he had a very noticeable lump/bulge in this area.

In [redacted] he injured his neck and right shoulder and scapula when performing a drill at the fire station. He reported this injury but did not receive treatment. Since this injury, he still has neck and right shoulder pain along with numbness in his back.

In [redacted] he injured his left ribs when he tripped and fell on top of the fire engine. He fell and hit his left ribs and kidney region. He went to a County hospital where X-rays were taken but they were unclear. He was told to rest and take Ibuprofen. He was off of work for 3 weeks.

In [redacted] he injured his right knee when jumping off a hose rack while at the fire station. MRI was taken and he tore his meniscus. He underwent a third surgery and participated in physical therapy, does not recall for how many sessions. The surgery did benefit him as far as returning to work but did not relieve the pain or his range of motion.

In [redacted] he injured his right shoulder when pulling off roofing material from a structure fire. He felt a pop; he reported the injury but does recall receiving treatment.

In [redacted] he injured his mid side abdominal pain (below the ribcage). He sought treatment and x-rays were taken but nothing was found but he still feels discomfort to this day.

In [redacted] he injured his neck and left shoulder when pulling hose and roofing materials during a structure fire. He received treatment for a torn bicep and surgery to repair the rotator cuff was completed. This was an outpatient procedure and physical therapy was completed for approximately 16 sessions. Both surgery and physical therapy helped him but he still has pain and discomfort in his neck and left shoulder.

In [redacted] he injured thoracic spine during training. He did receive treatment for this injury but does not recall the exact treatment that he received.

Mr. Doe states that he has received a total of 8-10 cortisone injections to his right knee; 4 injections to his left shoulder; 5-6 injections to his right shoulder and 1 injection to his left knee. He also received a round of 3 plasma injections to his right knee.

Mr. Doe does not recall seeing any other physicians or undergoing any other diagnostic testing or treatment.

He does not do a home exercise program. He uses both ice and heat, as needed. He wears a knee brace and back supporter as needed.

PRE-POST CAPACITY FOR LIFTING:

Prior to this claim, he states that he was able to lift and carry approximately 100+ pounds comfortably. Presently, he is able to lift and carry approximately 19 pounds comfortably.

PAST MEDICAL HISTORY:

He denies heart disease, diabetes, hypertension, lung disease, cancer, fibromyalgia, osteoporosis or blood disorders. He does have arthritis, scarring on his left lung and a heart murmur.

He denies any (other) prior or subsequent work, auto or sports-related accidents or injuries.

SOCIAL / RECREATIONAL HISTORY:

Mr. Doe is [redacted] and has [redacted].

He has problems showering due to bilateral shoulder pain.

He has problems putting on his shoes.

He has discomfort raking, digging, gardening, sweeping, mopping, vacuuming, making beds, cooking, preparing meals, grocery shopping.

He has problems driving longer than about 60-90 minutes due to right knee, right shoulder and lumbar spine pain. He has difficulty getting in and out of vehicles.

Pain in his right shoulder wakes him up every on occasion. Numbness in his neck will occasionally wake him up. He is no longer able to sleep while lying on his left side. He gets about 5 hours of sleep at night.

He denies internal complaints.

He limits intimate relations due to his symptoms.

He feels stressed due to his physical condition and the inability to function as before. He also experiences anxiety.

EXTRACURRICULAR ACTIVITIES:

Mr. Doe no longer rides motorcycles; no longer rides quads and no longer plays softball or baseball. He does not walk more than half a mile. He no longer does fly fishing. He does not golf as much as he used to. He no longer bowls or trail hikes. He no longer does deep sea fishing, stream or river fishing. He does not water ski anymore because “it’s more pain than it’s worth.”

He does not do any type of yard work anymore, or home repairs, he now relies on paid help. He cannot take long road trips anymore and if he does, he has to stop often to take breaks. Weight lifting is no longer something that he does either.

ALLERGIES & MEDICATIONS:

Mr. Doe states he is not allergic to any medications.

At the present time he is taking:

1. Ibuprofen 600 mg
2. Tylenol 500 mg
3. Flexeril 10 mg as needed
4. Tramadol 50 mg
5. Hydrocodone 325 mg

PRESENT COMPLAINTS:

EARS: Currently, Mr. Doe complains of constant ringing in both of his ears. He has had this for approximately [redacted] years due to the loud sirens from the fire engines that he drove or rode on.

NECK: Currently, Mr. Doe complains of constant to frequent pain in his neck. The pain varies between 5-7 on a scale of 1-10. He has headaches a few times a month. He is not certain if he associates his headaches with neck pain. The pain radiates into his bilateral shoulders. He experiences intermittent numbness and tingling in his bilateral arms, hands and fingers. He notices cracking or popping in his neck with turning of his head. His neck symptoms are increased by looking down, turning his head to the right, turning his head to the left, prolonged positioning of his head and neck.

BILATERAL SHOULDERS: Currently, Mr. Doe complains of intermittent pain in his shoulders, right greater than left. He rates his right shoulder pain as an average of 7 on a scale of 1-10 and his left shoulder pain as an average of 5 on a scale of 1-10. The pain from his shoulders does not radiate. He experiences intermittent numbness and tingling in his bilateral arms / hands / fingers. He notices cracking or popping and grinding in his bilateral shoulders with movement of his arms. His symptoms are increased by reaching forward, backward, laterally, overhead, repetitive use of his arms, lifting and carrying of objects.

MID BACK: Currently, Mr. Doe complains of frequent pain in his mid back. The pain varies between 3-7, on a scale of 1-10. The pain radiates to his right shoulder and chest. He has constant numbness in mid back. His symptoms are increased by twisting and turning, bending, lifting and carrying objects.

LOW BACK: Currently, Mr. Doe complains of constant pain in his low back. The pain varies between 3-8 on a scale of 1-10. The pain radiates into his left hip, buttock, leg and foot. The pain also radiates to his right hip, buttock, leg and knee. He experiences intermittent numbness and tingling in his left leg, foot and toes. He notes weakness in his bilateral legs. He limps frequently. He does not use a cane. His low back symptoms are increased by bending, stooping, squatting, kneeling, using stairs, sitting, standing and walking for prolonged minutes of time.

BILATERAL KNEES: Currently, Mr. Doe complains of constant pain in his knees, right worse than left. He rates his right knee pain varies in pain from 3-8 on a scale of 1-10 and his left knee pain from a 2-7 on a scale of 1-10. His right knee has radiating pain that

travels to his right calf. He has frequent to intermittent swelling in his right knee. He does not experience popping or cracking. He does not experience locking in the knees. He does not experience knee buckling. He limps intermittently due to right knee pain. He does not use a cane. His symptoms are increased by repetitive flexion, repetitive extension, stooping, squatting, kneeling, using stairs, prolonged standing and prolonged walking.

PHYSICAL EXAMINATION:

Height: [redacted] Weight: [redacted] pounds

He is an alert, well-nourished man who appears to be his stated age. He was not using any walking aids or braces. His gait is slightly antalgic on the right. The knees are well aligned. There is an increased Q angle bilaterally. He is able to do two-thirds of a deep knee bend with difficulty.

Examination of the cervical spine shows suboccipital as well as paracervical tenderness extending into the trapezius muscles. There is moderate muscle spasm with palpation of the trapezius regions bilaterally. There is guarding with range of motion. There is a negative foraminal compression test and a negative Spurling sign. There is no scapulothoracic crepitus or pain and no winging of the scapulae.

Comprehensive motor examination of the upper extremities including the shoulder abductors, flexors and extensors, the wrist flexors and extensors, the forearm supinators and pronators, the finger extensors, flexors and intrinsic muscles shows 5+/5+ motor power bilaterally.

Reflexes	Right	Left
Biceps tendon reflex	2+	2+
Triceps tendon reflex	2+	2+
Brachioradialis reflex	2+	2+

Comprehensive sensory examination of the upper extremities shows a normal dermatomal pattern to pinprick and deep touch.

Examination of the left shoulder shows multiple healed arthroscopic incisions. There is faint subacromial crepitus with circumduction. There is a negative Neer and a negative Hawkins impingement sign. There is a negative O'Brien's test. There is a negative apprehension sign. There is no deltoid muscle atrophy.

Examination of the right shoulder shows mild deltoid muscle atrophy. There is anterior subacromial tenderness with a positive Neer and a positive Hawkins impingement sign. There is a mildly positive O'Brien's test. There is a negative apprehension sign. There is no tenderness over the bicipital groove.

Upper extremity measurements:
Major Hand: Both

Circumferences:	Right	Left
Biceps at greatest circumference	30 cm	29.75 cm
Elbow	26.5 cm	26.75 cm
Forearm (2" below elbow)	26.25 cm	26 cm
Wrist	16.5 cm	16.5 cm
Hand	23 cm	23.5 cm

Grip strength: Jamar Dynamometer Readings

Right	Left
28 kg	30 kg
26 "	28 "
28 "	26 "

Examination of the thoracolumbar spine shows no scoliosis. There is tenderness extending from L3 to L5 along the paravertebral muscles. The straight leg raising sign is negative bilaterally.

Comprehensive motor examination of the lower extremities including extensor hallucis longus, anterior tibialis, gastrocsoleus, peroneus longus and brevis shows 5+/5+ motor power bilaterally.

Reflexes	Right	Left
Patellar tendon reflex	2+	2+
Achilles tendon reflex	2+	2+
Plantar response	Downward bilaterally	

Comprehensive sensory examination of the lower extremities shows a normal dermatomal pattern to pinprick and deep touch.

Examination of the right knee shows multiple healed arthroscopic incisions of the right knee. There is a mildly positive anterior Drawer sign and a mildly positive Lachman's test. There is a negative pivot shift test. There is no varus or valgus stress laxity. There is mild lateral and medial joint line tenderness. There is no effusion. There is no retropatellar crepitus or pain. There is right-sided quadriceps atrophy.

Examination of the left knee shows mild lateral and medial joint line tenderness. There is no effusion. There is no valgus, varus, anterior or posterior stress laxity. There is a negative Lachman's test and a negative McMurray's sign. There is no retropatellar crepitus or pain. There is a negative patellar apprehension sign.

Lower extremity measurements:

Circumferences	Right	Left
Mid-foot	28 cm	26.75 cm
Ankles (on the malleolus)	27 cm	27 cm
Ankles (smallest circ)	22.5 cm	22 cm
Calves (largest circ)	40.5 cm	40 cm
Knees (on the patella)	41 cm	41 cm
Thighs (mid-thigh - 1/3 of distance between upper pole of patella and umbilicus	46.5 cm	46.75 cm

Leg lengths:	Right	Left
Anterior superior spine to tip of malleolus (actual)	97 cm	97 cm

X-RAYS:

X-rays of the cervical spine, bilateral shoulders, lumbar spine and bilateral knees were obtained on [redacted] and interpreted by [redacted] M.D., [redacted]

X-rays of the cervical spine, 3 views, were interpreted with the impression: There is moderate C5-6 degenerative disc disease. There is likely mild C6-7 degenerative disc disease. There is straightening of the cervical lordosis.

X-rays of the right shoulder, 3 views, were interpreted with the impression: There is mild acromioclavicular joint osteoarthritis.

X-rays of the left shoulder, 3 views, were interpreted with the impression: There are humeral heads stabilizing suture anchors for rotator cuff repair. Internal derangement may be further evaluated with MRI.

X-rays of the lumbar spine, 3 views, were interpreted with the impression: No significant abnormality. The findings indicate the lumbar lordosis is straightened.

X-rays of the right knee, 3 views, were interpreted with the impression: Mild medial compartment osteoarthritis. The findings include mild medial compartment osteoarthritis, and lateral meniscus chondral calcinosis.

X-rays of the left knee, 3 views, were interpreted with the impression: Left knee series demonstrates no significant abnormality.

REVIEW OF RECORDS:

The following is a review of records on the above captioned patient:

[Portions of this review have been completed by provider/facility rather than being reviewed solely chronologically due to the overlapping of treatment.]

On [redacted] x-rays of the lumbar spine and chest were obtained at General Hospital ***** County at the referral of Dr. *****. These were interpreted by *. *****, M.D. as follows:

> Lumbar spine: The lumbar vertebrae, discs, zygoapophyseal articulations and the sacroiliac joints are normal. Conclusion: Normal lumbar spine.
>
> Chest: Heart size and configuration are normal. The lungs are clear. The bones and soft tissues are normal for age. Conclusion: Normal chest.

A Doctor's First Report of Injury dated [redacted] by *. *****, M.D. indicates that the patient presented to the emergency department [facility not indicated] on that date because of a small laceration to his distal left index finger sustained at work earlier that day while sharpening knives. On examination, there was a 1 cm superficial laceration flap over the distal tip of the left index finger. The diagnosis was laceration to the left index finger and work related examination. Steri-strips were placed to close the laceration and the patient was to return to work on that day.

A Doctor's First Report of Injury by ***** *****, M.D. dated [redacted] notes that Mr. Doe was seen on that date for excruciating low back pain, back spasms and difficulty standing and sitting. The patient had no recollection of any direct trauma to his lower back. Examination revealed difficulty with gait when upright. He had great difficulty sitting and standing as well as leg lifting. X-rays of the back showed some lipping of the L2 vertebra. The diagnoses were lumbar paraspinous muscle spasm and work related examination. Motrin, Flexeril and Vicodin were prescribed and the patient was advised not to lift.

X-rays of the lumbosacral spine were performed at ***** ***** Hospital on [redacted] and were interpreted by *. *****, M.D. as follows:

> [History and comparison not reported.]
>
> Findings: There is anatomic alignment of the lumbar spine, with maintenance of the vertebral body heights. Minimal osteophyte formation is noted at the L2-3 level. The pedicles appear symmetric. There is no cortical erosion or destruction.
>
> Impression: Minimal degenerative changes of the lumbar spine, without evidence of fracture or cortical erosion.

An emergency department depart summary from ***** ***** Hospital dated [redacted] notes that Ms. Doe was brought in on that date because of a right lower leg injury. An ultrasound venous duplex study was done and the patient was diagnosed with a contusion soft tissue. He was discharged home with prescriptions.

On [redacted] an ultrasound right lower extremity venous duplex study was performed at ***** ***** Hospital at the request of ***** *****, M.D. This was interpreted by ***** *****, M.D. with the following impression:

1. No evidence of deep vein thrombosis is noted of the bilateral common femoral veins and right lower extremity.
2. The right greater and lesser saphenous veins are intact.
3. Clinical correlation is recommended.

Radiographs of the chest were obtained on [redacted] at ***** Imaging Centers at the request of ***** *****, M.D., and were interpreted by ***** *****, M.D. as follows:

> Indications: Patient has a cough.
>
> Comparison: Chest radiograph 5/7/07.
>
> Findings: The lung fields appear to clear of infiltrates. No pulmonary masses are detected. No evidence of pleural fluid nor pneumothorax is present. The cardiomediastinal silhouette is unremarkable as is the pulmonary vasculature.
>
> The osseous structures show no evidence of a destructive lesion nor fracture. Degenerative changes are noted of the thoracic spine.
>
> Impression: No radiographic evidence of acute cardiopulmonary disease.

According to a Doctor's First Report of Injury, Mr. Doe was seen by ***** *****, D.O. on [redacted] because of right knee pain after jumping off a hose drying rack on [redacted] Note was made of prior meniscal injuries to this knee. Examination of the right knee showed lateral joint line tenderness. The diagnosis was right knee pain. He was referred for orthopedic surgery evaluation and treatment, and x-rays and an MRI of the right knee were ordered.

X-rays of the right knee were ordered by ***** *****, D.O. and were done on [redacted] at ***** ***** Hospital. These were interpreted by ***** *****, M.D. as follows:

Indications: 2 weeks pain s/p injury.

Comparison: None.

Findings:

BONES: There is no evidence of fracture or destructive lesion. There is minimal arthritic change present with minimal spurring of the patella and medial tibial plateau.
SOFT TISSUES: There is faint chondrocalcinosis present.
EFFUSION: None visible.
OTHER: Negative.

Conclusion: There is minimal arthritic change with faint chondrocalcinosis present.

There is another Doctor's First Report of Injury by Dr. ***** dated [redacted] indicating the patient was seen on that date for left shoulder pain. He reported working with heavy hoses on [redacted] noting pain in the front of the left shoulder. Examination of the left shoulder showed subacromial bursa tenderness and supraspinatus muscle tenderness. Range of motion was painful. There was a positive drop arm test and a positive empty can test. The diagnosis was pain in joint of left shoulder. Orthopedic surgery referral was made and x-rays and an MRI of the left shoulder were ordered.

X-rays of the left shoulder were ordered by ***** *****, D.O. and were done on [redacted] at ***** ***** Hospital. These were interpreted by ***** *****, M.D. as follows:

Indications: Sudden pain s/p 11 days injury.

Comparison: None.

Findings:

BONES: Normal. No significant arthropathy or acute abnormality.

SOFT TISSUES: Negative. No visible soft tissue swelling.
OTHER: No other significant finding.

Conclusion: Unremarkable left shoulder.

An MRI of the right knee was ordered by ***** *****, D.O. and was obtained on [redacted] at ***** Imaging Centers. This was interpreted by ***** *****, M.D. as follows:

Indication: Knee pain.

Comparison: Right knee radiographs[redacted]

Findings:

MEDIAL COMPARTMENT: An oblique tear of the posterior horn of the medial meniscus is noted extending through the inferior articular surface and its periphery. No evidence of bucket-handle deformity is noted. Some linear increased signal intensity extends towards the meniscal root consistent with horizontal cleavage tear in this region. The articular cartilage is intact.

LATERAL COMPARTMENT: The lateral meniscus is normal in contour and signal intensity without evidence of tear. The articular cartilage is intact.

PATELLOFEMORAL COMPARTMENT: Focal chondral irregularity is noted along the lateral patellar facet at its junction with the medial facet consistent with chondromalacia. The extensor retinaculum is intact.

LIGAMENTS AND TENDONS: The cruciate and the collateral ligaments are intact. The popliteus and pes anserine tendons are unremarkable. The quadriceps and patellar tendons are intact.

OSSEOUS STRUCTURES: Normal bone marrow signal intensity is maintained.

A small joint effusion is noted. The visualized muscle groups are unremarkable.

Impression:

1. Oblique tear at the periphery of the posterior horn medial meniscus with horizontal cleavage tear extending into the meniscal root.

2. Focal chondromalacia changes lateral patellar facet.

3. Small joint effusion.

An MRI of the left shoulder was ordered by ***** *****, D.O. and was obtained on [redacted] at ***** Imaging Centers. This was interpreted by ***** ***** III, M.D. as follows:

Indication: Left shoulder pain.

Comparison: Shoulder radiographs[redacted]

Findings:

Some thickening and intermediate signal intensity is noted of the distal supraspinatus tendon suggestive for tendinosis. On the sagittal images a focus of increased signal intensity is noted along the undersurface which could indicate a partial thickness undersurface tear. The subscapularis tendon appears to be intact. The long head of the biceps tendon resides in a normal position within the biceps groove.

The glenohumeral articulation is anatomic. No labral tears are identified. The biceps lateral complex is intact.

The acromioclavicular joint shows mild hypertrophic changes. Lateral downsloping of the acromion is noted on the coronal projection. The coracoacromial ligament is normal in thickness. The coracoclavicular ligament is intact. Reactive marrow changes are noted within the distal clavicle and opposing acromion. A small amount of subacromial fluid is noted consistent with physiologic fluid versus bursitis. No evidence of shoulder joint effusion is noted.

The osseous structures show no evidence of a fracture nor destructive lesion.

Impression:

1. Thickened distal supraspinatus tendon with intermediate signal intensity consistent with tendinosis. Probable partial thickness undersurface tear at its insertion into the greater tuberosity.

2. Mild hypertrophic changes acromioclavicular joint and lateral downsloping of the acromion on the coronal projection. These factors might increase the risk for anatomic impingement.

On [redacted] ***** *****, M.D. of ***** ***** ***** ***** evaluated the patient for right knee pain he sustained when he jumped off a hose on [redacted] On examination, the patient had an antalgic gait on the right. Healed scars were noted on the right knee. There was tenderness in the right medial joint line with crepitus. Trace effusion was noted. Radiographs of the right knee were obtained on that date, showing mild medial and PFJ asymmetric joint space narrowing. Evidence of chondrocalcinosis was noted. The impression was right knee pain, recurrent medial meniscus tear, chondromalacia with chondrocalcinosis, early OA medial compartment PFJ and status post OPA with medial meniscectomy, distant past (x2). The recommendation was to proceed with surgical arthroscopy with revision partial medial meniscectomy, chondroplasty and debridement. The doctor discussed the stepwise approach to management of early osteoarthritis of the knee and treatment options including activity modification, anti-inflammatories, low impact low resistance physical therapy and use of hyaluronic viscosupplementation.

Mr. Doe was seen by ***** *****, M.D. at ***** ***** ***** ***** on [redacted] due to left shoulder pain after pulling a hose on [redacted] On examination, there was a mildly painful range of motion of the left shoulder with mild crepitus. Mild anterior and lateral pain was also noted. Supraspinatus and infraspinatus strength was 4/5. Impingement sign was positive. Radiographs of the left shoulder were obtained on that date, showing a type IIB acromion. The impression was minimally symptomatic partial cuff tear, left shoulder. Dr. ***** recommended observation and no specific limitations.

***** *****, PA-C for Dr. ***** saw the patient on [redacted] for preoperative discussion regarding right knee arthroscopy. Examination showed tenderness to palpation over the medial joint line and restricted flexion. The impression was right knee pain, medial meniscal tearing/degeneration and chondromalacia. The plan was to proceed with surgical arthroscopy of the right knee with careful evaluation of the medial meniscus with any necessary partial medial meniscectomy, chondroplasty and debridement.

Chest x-rays were ordered by ***** *****, M.D. and were performed on [redacted] at ***** ***** Hospital. These were interpreted by ***** *****, M.D. as follows:

Indications: Pre op.

Comparison: ***** Imaging Center, Chest, [redacted]

Findings:

LUNGS: Atelectasis and/or consolidation adjacent to the left lung base.
VASCULATURE: The pulmonary vascularity is within normal limits. The aorta is unfolded and calcified.
CARDIAC: Normal. No cardiac silhouette abnormality or cardiomegaly.
MEDIASTINUM: Normal. No visible mass or adenopathy.
PLEURA: New left basilar small volume pleural effusion.
BONES: Normal. No fracture or visible bony lesion.

Conclusion:

1. New left basilar pleural effusion with adjacent atelectasis and/or consolidation.
2. Remainder of the examination is unchanged from [redacted]

An operative report by ***** *****, M.D. at ***** Surgery Center dated [redacted] notes that the patient underwent the following procedures on that date:

1. Surgical arthroscopy of the right knee with partial medial meniscectomy.
2. Partial lateral meniscectomy.
3. Chondroplasty medial and patellofemoral compartments.

The preoperative diagnoses:

1. Right knee pain.
2. Medial meniscal tear.
3. Chondromalacia.

The postoperative diagnoses:

1. Complex tear medial meniscus, right knee.
2. Chondrocalcinosis.
3. Mid zone degenerative tear lateral meniscus, right knee.
4. Chondromalacia grade III, medial femoral condyle.
5. Chondromalacia grade II, superficial grade III, patellofemoral joint.

There were no complications noted.

The patient returned to see **. ***** on [redacted] approximately a week status post right knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, chondroplasty and debridement of pseudogout. He was doing well with decreasing pain every day. Examination showed the incisions to be healing well. The sutures were removed and Steri-strips applied. He was instructed to keep the incisions clean and dry and continue icing two or three times a day. A prescription for physical therapy was given.

There is a physical therapy initial examination by ***** *****, P.T. at ***** ***** Physical Therapy dated [redacted] Mr. Doe was seen on that date, eight days post medial and lateral meniscectomy of the right knee. Right knee range of motion was decreased and muscle strength for right knee flexion and extension were 4/5 ad 4+/5 respectively. Note was made that he recently performed a squat which exacerbated his knee pain and he was advised to refrain from exceeding 90° knee flexion for the next month. He was started on physical therapy one to two times a week for six weeks

including therapeutic exercises, therapeutic activity, gait training, neuromuscular rehabilitation and manual therapy.

Mr. Doe was seen by ***** *****, M.D. on [redacted] for non-orthopedic issues but note was made that he had a very bad right knee requiring arthroscopic surgery.

On [redacted] x-rays of the left hip and pelvis were obtained at ***** ***** Hospital at the request of ***** *****, M.D. These were interpreted by ***** *****, M.D. as follows:

Indications: Left hip/pelvis pain.

Comparison: None.

Findings:

BONES: Mild degenerative changes of both hips.
SOFT TISSUES: Negative. No visible soft tissue swelling.
OTHER: No other significant finding.

On [redacted] Mr. Doe was seen by Dr. ***** for lab results, but note was made that his soft tissue hip pain resolved and he was advised to do stretching exercises. The remainder of the report pertained to non-orthopedic issues.

Dr. ***** reevaluated the patient on [redacted] and noted he was doing well with decreasing pain every day and getting stronger with physical therapy. Examination showed the incisions to be healing well. Mild periportal scarring was noted. Mr. Doe was instructed to continue icing 2-3 times a day as needed. Physical therapy as continued and he was advised to avoid high impact, high resistance exercises.

Mr. Doe underwent a Physical Therapy Initial Examination by ***** *****, P.T. at ***** Physical Therapy on [redacted] Note was made that he had undergone 6-8 treatments at ***** ***** Physical Therapy but ***** Physical Therapy was much closer to his home so he wished to switch clinics. On examination, the right knee as noted to be edematous and there were well healed scope sites. There was patella alta of the right knee. Mild left hamstring atrophy was noted from an old injury, and mild right quadriceps atrophy from post injury and surgery. Thomas test was positive for rectus femoris. There was painful crepitus noted with patellar compression. The medial and inferior patella was hypomobile. The patient was unable to fully squat or kneel. He was

started on a course of treatment twice a week for four weeks including therapeutic exercise, therapeutic activity, neuromuscular rehabilitation, manual therapy, and splinting/taping.

There is a primary treating physician's initial orthopedic evaluation report dated [redacted] by ***** *****, M.D. The patient was seen on that date for work related injuries on [redacted], [redacted] as well as a CT from [redacted]. The history notes that he developed low back pain 20 years prior from his work activities. On [redacted] he injured his left hamstring [mechanism of injury not given]. Then on [redacted], he was jumping off a hose and injured his right knee. He injured his left shoulder on [redacted] while pulling a hose off a truck. Past history noted right knee arthroscopy in [redacted] and [redacted] He also had left thumb surgery 20 years prior. His complaints at the time of this examination were lumbar spine pain radiating into both lower extremities, right knee pain, clicking and limited range of motion, left shoulder pain and limited range of motion and left thigh residual discomfort.

On examination of the left shoulder, there was tenderness to palpation over the anterior rotator cuff with mild AC joint and bicipital tenderness. There was a positive impingement sign. Examination of the lumbar spine showed tenderness over the upper, mid and lower paravertebral muscles and increased pain with lumbar extension. Pelvis, bilateral hip and left thigh examination was unremarkable. Exam of the right knee showed a well healed nontender arthroscopic incision. Tenderness to palpation was noted over the medial compartment as well as mild patellofemoral irritability. Quadriceps/hamstring strength was 4/5. Range of motion caused mild crepitation. Pain in the right knee was noted with duck waddling/squatting. The diagnoses:

1. Left rotator cuff tendinitis and impingement syndrome with probable partial thickness rotator cuff tear.
2. Status post right knee arthroscopy with arthroscopic partial medial and lateral meniscectomy and chondroplasty, [redacted]
3. Chronic lumbar spine strain.
4. Chronic lumbar radicular syndrome.
5. History of left hamstring injury.

Dr. ***** stated the patient had not reached maximum medical improvement and that there would be no apportionment to any preexisting disability or orthopedic pathology. He recommended that the patient complete his right knee postoperative therapy and

request was made for a lumbar MRI scan. The patient was instructed in soft tissue modalities, exercises for range of motion and strengthening.

A Physical Therapy Discharge Summary by Ms. ***** dated [redacted] at which time there was noted to be less edema in the right knee and mild end-range pain complaints due to persistent subpatellar crepitus. Patella alta was still present due to right quadriceps and poor follow through with stretching. His goals were met and the patient was to continue his home exercise program at the gym and his fire station. He was discharged from treatment.

A 67-page deposition testimony of John Doe taken on [redacted] is reviewed. Mr. Doe stated that he was hired as a firefighter/engineer in [redacted] and concurrently worked on movie sets four times a year although he had not done this in approximately [redacted] years. He denied any injuries or accidents while working on movie sets. Prior to working for County of *****, he worked for ***** ***** County Fire for three and a half years. He recalled injuring his fingers, eyes, head and right ankle while employed there. He stated he had been involved in one motor vehicle accident in approximately [redacted] when he was rearended while at a stop. He did not seek medical attention as a result of this accident. He also noted another motor vehicle accident when he was seven years old but denied suffering bodily injury. He had a motorcycle accident in [redacted] when he hit a patch of oil, and scraped his right hand. He was seen at ***** ***** Hospital and lost approximately a month from work as he could not grip. Then around [redacted] he had another motorcycle accident when he was thrown off after hitting a berm. He suffered injuries to his right thumb and right shoulder/collarbone and was seen at ***** ***** Hospital. He fractured his collarbone and lost approximately one month of work. Mr. Doe also stated he had surgery to the right thumb involving a pin and followed up at ***** ***** ***** ***** Medical Center. He further noted that he suffered sports related injuries after college consisting of broken fingers. There was also an injury at home in approximately [redacted] when he fell about three feet off a ladder at home, injuring his right leg.

Mr. Doe stated his primary care physician was Dr. ***** and Dr. *****. He noted that he was hospitalized twice, once for salmonella at ***** ***** Hospital and then for a leakage from his first knee surgery at ***** *****. He indicated he suffered two work related injuries to his right knee in the mid to later [redacted] resulting in two right knee surgeries. On [redacted] he was exposed to asbestos which affected his eyes and lungs. He also recalled being off work for at least a month with a mid-thoracic injury possibly between [redacted] after lifting a 600 pound patient. He was seen at ***** Hospital and then treated with Dr. ***** *****. He then stated he had an

injury to his right ankle on [redacted] while climbing down the side of an embankment. There was an injury to the right elbow on [redacted] mentioned, but Mr. Doe could not recall that injury. The next injury was on [redacted] when he was exposed to tuberculosis but did not develop it. On [redacted] he lifted a heavy gurney injuring his low back and was seen at ***** ***** Hospital. On [redacted] he was jogging and his foot went into a hole in the ground causing injury to his right knee and hip. Then on [redacted] he lifted a patient onto a gurney from a toilet and strained his low back. The next injury mentioned in the deposition was on [redacted] to his left hamstring while pulling a hose. After this was a [redacted] injury to his left upper back while doing PT. On [redacted] he hurt his left hip while pulling a hose, and on [redacted] he injured his low back while moving a large patient. There was mention of a right shoulder and neck injury on [redacted] On [redacted] he jumped off a hose rack and injured his right knee, and two days later he injured his left shoulder pulling and twisting a hose. Mr. Doe testified that he was treated by Dr. ***** and Dr. *****, who did arthroscopic surgery to his knee. The deposition was then adjourned to another volume.

On [redacted] ***** *****, M.D. saw the patient for an Orthopedic Agreed Panel Qualified Medical Evaluation for the continuous trauma from [redacted] with complaints of pain in both shoulders, thoracic spine, lumbar spine, left hamstring and right knee. Examination of both shoulders showed decreased range of motion with pain bilaterally on flexion, internal and external rotation as well as pain with adduction of the left shoulder. Thoracic spine examination showed tenderness at T10 and tenderness and spasm in the thoracic paravertebrals. There was tenderness of the interscapular muscles on the right. There was pain and spasm with left thoracic rotation. Examination of the lumbar spine showed slight tenderness and spasm of the lumbar paravertebrals as well as slight tenderness and spasm of the sacroiliac joints bilaterally. Pain and spasm was noted with lumbar left lateral bending. Straight leg raising was positive with localized pain bilaterally. Right knee examination showed three well healed arthroscopic portals. There was tenderness of the lateral and medial joint lines of the right knee and medial femoral condyle of the left knee.

X-rays of the left shoulder were obtained, showing a 4 mm AC joint space with degenerative changes noted at the acromion. The glenohumeral joint space measured 5 mm. X-rays of the thoracic spine showed significant lipping and bridging similar in appearance to possibly DISH involving more than 50% of the thoracic spine. There were calcifications throughout the bronchioles. There also appeared to be degenerative changes at the first rib. Scoliosis was noted at the thoracolumbar junction possibly due to spasm or bony anomalies. X-rays of the lumbar spine demonstrated loss of lordotic curve

with diminished disc spacing at L3-4 and some compression of L3. There was decreased space at the L4-5 and L5-S1 disc levels and degenerative disc disease. X-rays of the right knee showed some chondromalacia patella. There was 7 mm of patellofemoral joint space and 4 mm of medial and lateral joint spacing. There was blunting of the tibial eminences. Overall, degenerative arthritic changes were seen. The diagnostic impressions:

1. Chronic musculoligamentous sprain, lumbar spine with sciatica.
2. Chronic strain, right knee.
3. There is minimal arthritic change with faint chondrocalcinosis present.
4. Oblique tear at the periphery of the posterior horn medial meniscus with horizontal cleavage tear extending into the meniscal root. Focal chondromalacia changes lateral patellar facet. Small joint effusion.
5. S/P right knee arthroscopy x 3, [redacted] with partial medial meniscectomy, partial lateral meniscectomy, chondroplasty medial and patellofemoral compartments.

It was Dr. *****'s opinion that there was a cumulative trauma as it pertained to the back and right knee with a reasonable degree of medical probability. On questioning the patient, note was made of a right shoulder injury "last night" while handling power tools. The doctor requested an MRI of the thoracic and lumbar spine and an MR arthrogram of the right knee. He felt the patient could continue working without restrictions.

An MRI of the thoracic spine was ordered by ***** *****, M.D. and was performed on [redacted] at ***** Imaging Centers. This was interpreted by ***** *****, M.D. as follows:

> Indications: Pain with pain radiating to the right shoulder and scapula.
>
> Comparison: None.
>
> Findings:
>
> There is a dextroscoliosis of the upper thoracic spine and a levoscoliosis of the lower thoracic spine.
>
> "Degenerative" disc changes are present within the mid to lower thoracic spine, greatest from T9-T10 through T11-T12.

At T6-T7, there is a 2 mm right paracentral disc protrusion with no impingement.

The vertebral body heights are well maintained.

There is no evidence of a fracture.

There are no abnormalities of the spinal cord.

Impression:

1. Dextroscoliosis of the upper thoracic spine and levoscoliosis of the lower thoracic spine.

2. “Degenerative” changes, greatest from T9-T10 through T11-T12.

3. T6-T7 2 mm right paracentral disc protrusion with no impingement.

An MRI of the lumbar spine was ordered by ***** *****, M.D. and was performed on [redacted] at ***** Imaging Centers. This was interpreted by ***** *****, M.D. as follows:

Indications: [redacted]-year-old male with low back pain with radiculopathy (pain radiating down the back of the left leg).

Comparison: None.

Findings:

There is a levoscoliosis.

At L1-L2, no significant pathology is present.

At L2-L3, there are minimal lateral disc bulges, greater on the left.

At L3-L4, there are “degenerative” disc changes with a 3 mm disc bulge extending laterally into both neural foramina, greater on the left, narrowing the left neural foramen and impinging upon the left exiting nerve roots.

At L4-L5, there are "degenerative" disc changes with a 3-4 mm broad-based disc bulge, greater laterally, with disc material extending into both neural foramina. Facet arthropathy and hypertrophy contribute to mild central canal and moderate bilateral foraminal stenoses, greater on the right, impinging upon the exiting nerve roots bilaterally.

At L5-S1, there is a 1-2 mm disc bulge with facet arthropathy.

There are no intrinsic abnormalities within the central canal.

Impression:

1. Levoscoliosis.

2. L3-L4 3 mm disc bulge extending laterally into both neural foramina, greater on the left, narrowing the left neural foramen and impinging upon the left exiting nerve roots.

3. L4-L5 3-4 mm broad-based disc bulge, greater laterally, with disc material extending into both neural foramina. Facet arthropathy and hypertrophy. Mild central canal and moderate bilateral foraminal stenoses, greater on the right, impinging upon the exiting nerve roots bilaterally.

4. Lesser findings as described above.

On [redacted] an MR arthrogram was done of the right knee at the request of ***** *****, M.D. This was interpreted by ***** *****, M.D. as follows:

Indication: Status post right knee surgery, right knee pain.

Comparison: Limited comparison is made with [redacted]

Findings:

MENISCI: The middle third and posterior horn of the medial meniscus is small and irregularly shaped but no definite linear contrast is seen extending into the meniscus. This is probably postsurgical change. Nevertheless, there is considerable indistinctness of the meniscus at the junction of the middle and posterior thirds and some component of maceration in this area cannot be

excluded. The lateral meniscus appears truncated in the middle third, likely related to previous surgery.

LIGAMENTS: The anterior and posterior cruciate ligaments and medial and lateral collateral ligament complexes appear intact.

BONES AND SOFT TISSUES: A focal defect is present in the medial facet of the patella that appears to have progressed since the previous study. This is full thickness or near full thickness. There is generalized thinning of the hyaline cartilage in the medial and lateral compartments with slight irregularity but no subcortical marrow edema.

Impression:

1. Small middle third and posterior horn of the medial meniscus with an irregular shape, likely related to previous surgery.

2. Diffuse increased signal intensity in the medial meniscus at the junction of the middle and posterior thirds which could be an area of maceration or may simply be postoperative changes.

3. Truncation of the free edge of the middle third of the lateral meniscus, likely due to previous surgery.

4. Focal near full thickness cartilage defect in the medial facet of the patella, progressed since the previous study.

5. Generalized chondromalacia in the medial and lateral compartments.

There is an MRI of the right shoulder dated [redacted] [facility not indicated] which was ordered by ***** *****, D.O. This was interpreted by ***** *****, M.D. as follows:

Indications: [redacted]-year-old male with right shoulder pain and numbness.

Comparison: None.

Findings:

There is irregularity and increased signal within the rotator cuff consistent with tendinosis and "partial tearing." No specific MRI evidence of a full thickness tear or muscular retraction.

There is increased signal within the anterosuperior glenoid labrum suspicious for a tear.

There are moderate hypertrophic changes at the acromioclavicular joint with a downsloping acromion.

The long head of the biceps tendon is intact.

Impression:

1. Irregularity and increased signal within the rotator cuff consistent with tendinosis and "partial tearing."

2. Increased signal within the anterosuperior glenoid labrum suspicious for a tear.

3. Moderate hypertrophic changes at the acromioclavicular joint with a downsloping acromion. These findings may contribute to a clinical impingement syndrome.

Mr. Doe returned to Dr. ***** on [redacted] and noted that he had been having problems with his right shoulder, which had been accepted as a work related condition. On examination, there was tenderness over the right and left anterior rotator cuff and mild AC joint and bicipital tenderness bilaterally. Impingement sign was positive bilaterally. Examination of the lumbar spine showed tenderness to palpation over the upper, mid and lower paravertebral muscles. Increased pain was noted with lumbar extension. Right knee examination showed a well healed nontender arthroscopic incision. There was tenderness to palpation over the medial compartment and mild patellofemoral irritability. Quadriceps/hamstring strength was 4/5. The diagnoses:

1. Left rotator cuff tendinitis and impingement syndrome with probable partial thickness rotator cuff tear.
2. Status post right knee arthroscopy with arthroscopic partial medial and lateral meniscectomy and chondroplasty, [redacted]
3. Chronic lumbar spine strain.
4. Chronic lumbar radicular syndrome.

5. History of left hamstring injury.
6. Degenerative joint disease and degenerative disc disease of the lumbar spine with protrusion at L3-4, L4-5 and L5-S1.
7. Thoracic spine strain.
8. Degenerative joint and degenerative disc disease of the thoracic spine with protrusion at T6-7.
9. Right rotator cuff tendinitis, impingement syndrome and partial rotator cuff tear.

The patient was instructed in soft tissue modalities, exercise for range of motion and strengthening. Corticosteroid and epidural injections were discussed and he was advised to complete his postoperative therapy for the right knee. Authorization was requested for an MRI of the lumbar spine.

There is a supplemental report by Dr. ***** dated [redacted] in which the doctor reviewed diagnostic studies and provided MMI status. He felt that Mr. Doe's treatment was considered medically reasonable. For the thoracic spine, 8% whole person impairment was provided, DRE II. For the lumbar spine, he was considered DRE III, 13% whole person impairment, and per range of motion rating, he had a total of 12% whole person impairment, with 2% add on for pain. For the right knee, 4% whole person impairment was calculated for partial medial and lateral meniscectomy, as well as 1% for pain. Work restrictions were not required. Apportionment for the right knee was 10% to the September [redacted] injury and 90% to cumulative trauma. Future medical care included epidural steroid injections, viscosupplementation and/or cortisone injections, medications and possibly total knee arthroplasty.

On [redacted] Mr. Doe was seen by ***** *****, M.D. [orthopedic surgery] for injuries to his shoulders, left hamstring, back and right knee. Note was made of another injury on [redacted] when he was pulling some roofing material after a fire and injured his right shoulder. Examination showed that palpation of the lumbar paraspinal and quadratus lumborum muscles revealed tenderness and hypertonicity bilaterally. There was tenderness over the lumbar spine and a positive straight leg raise test bilaterally. Examination of the shoulders showed decreased range of motion bilaterally. Speed's and Yergason's tests were positive on the right and Neer and Hawkins impingement tests were positive bilaterally. Examination of the right knee revealed surgical portal scars and tenderness to palpation over the medial and lateral joint line. Range of motion was slightly decreased. Patellofemoral grind test was positive. The diagnoses:

1. Right shoulder superior labrum tear with biceps tear and rotator cuff impingement.
2. Left shoulder rotator cuff partial tear with impingement.

3. Lumbar disc herniation with lower extremity radicular pain.
4. Right knee meniscal tear, status post arthroscopy x 3.
5. Right knee posttraumatic degenerative change.
6. Right knee patellofemoral pain with chondromalacia.

It was Dr. *****'s opinion that his injuries, with significant medical probability, arouse out of and in the course of his employment. He stated that the patient was a great candidate for platelet rich plasma injections for the right knee. A left shoulder MRI scan was recommended and Tramadol and Flexeril were prescribed.

A PR-2 report by Dr. ***** dated [redacted] notes that the patient was seen on that date with lumbar spine, bilateral shoulder and right knee pain. Examination showed tenderness over the midline lumbar spine with tenderness and hypertonicity over the paraspinal musculature and asymmetric loss of range of motion. Medial tenderness was noted of the right knee with mild crepitus on passive range of motion. A platelet rich plasma injection was given to the right knee. Authorization for an MRI of the left shoulder was pending.

There is an MRI of the cervical spine dated [redacted] [facility not indicated] which was ordered by ***** *****, M.D. This was interpreted by ***** *****, M.D. as follows:

> Indications: Neck pain and stiffness and weakness radiating into the left shoulder for a few months following an injury.
>
> Comparison: None.
>
> Findings: The study is somewhat limited technically due to low signal-to-noise.
>
> The vertebral bodies have normal marrow signal without evidence of tumor. There are degenerative marrow changes around the disc spaces particularly at C5-C6.
>
> The spinal cord has normal intensity but is slightly indented at C5-C6. The cervicomedullary junction is unremarkable.
>
> C2-C3 normal.
>
> C3-C4 normal disc space height with 1-2 mm of posterior disc bulging without stenosis.

C4-C5 normal disc space height with small anterior osteophytes and 2 mm of central broad based disc protrusion touching the spinal cord but without spinal cord compression or spinal stenosis. There is mild encroachment upon the foramina bilaterally.

C5-C6 moderate disc space narrowing with mild anterior ridging and 3 mm of central posterior broad based disc protrusion reducing the AP dimension of the dural sac to about 8 mm and causing spinal stenosis with probable slight compression of the spinal cord. There is also bilateral moderate foraminal encroachment.

C6-C7 normal disc space height with moderate anterior osteophytes and 2 mm of posterior disc bulging and a 1 mm central focal disc protrusion with reduction of the AP dimension of the dural sac to about 9 mm without cord compression or foraminal encroachment.

C7-T1 normal.

Impression:

1. Mild degenerative disc changes predominantly from C4 to C7.

2. C5-C6 3 mm central broad based disc protrusion causing mild spinal stenosis and possible slight cord compression with associated bilateral moderate foraminal encroachment.

3. C4-C5 1-2 mm central broad based disc protrusion without stenosis.

4. C6-C7 mild spinal stenosis secondary to disc bulging and a possible 1 mm central disc protrusion.

5. Other findings as described above.

A left shoulder arthrogram was done on [redacted] [facility not indicated] which was ordered by ***** *****, M.D. This was interpreted by ***** *****, M.D. as follows:

Indications: Left shoulder pain and weakness with loss of range of motion for 2 months.

Comparison: None.

Findings:

OSSEOUS: Alignment is normal. No acute fracture or suspicious osseous lesion.
ARTICULAR: No advanced degenerative arthrosis. Articular cartilage is normal for age.
ROTATOR CUFF: There is moderate to high grade (approximately 60% tendon thickness), partial thickness articular surface tear of the supraspinatus tendon in the critical zone, and at the medial aspect of the footprint, measuring approximately 1.1 cm and the anteroposterior dimension and 1.3 cm in the transverse plane. There is infraspinatus tendinosis, with possible low grade, partial thickness undersurface tear at the footprint. The teres minor and subscapularis tendons are unremarkable. No significant muscular atrophy or edema.
ACROMION: There is a type II acromion with lateral downsloping. There is a 6 mm subacromial enthesophyte at the coracoacromial ligament attachment.
AC JOINT: Mild degenerative changes of the acromioclavicular joint.
LIGAMENTS: Mild thickening of the proximal coracoacromial ligament. Axillary pouch ligaments and coracoclavicular ligaments appear unremarkable.
LABRUM: Contrast imbibition beneath the superior and anterosuperior portions of labrum, suggesting a normal variant sub-labral foramen. Remainder of the labrum is unremarkable.
BICEPS: Anchor and tendon are intact. No evidence of tenosynovitis.
OTHER: Satisfactory joint distention. No significant bursal fluid. No ganglion cyst or mass lesion seen.

Conclusion:

1. Moderate to high grade, partial thickness, articular surface tear of the supraspinatus tendon in the critical zone.
2. Type II acromion with lateral downsloping and a 6 mm subacromial enthesophyte. Correlate for signs of extrinsic impingement.
3. Mild fluid in the subacromial/subdeltoid bursa.
4. Suggestion of low grade, partial thickness, articular surface tear of the infraspinatus tendon.

5. Mild osteoarthrosis of the acromioclavicular joint.

On [redacted] Dr. ***** saw the patient again for his lumbar spine and right knee Right knee examination showed medial tenderness and mild crepitus with passive range of motion. It was noted that the platelet rich plasma injection helped about 30% and was still helping. Authorization was requested for a series of five Supartz injections for the right knee.

Dr. ***** reevaluated Mr. Doe on [redacted] for his right knee and requested authorization for viscosupplemental injections. The patient was to continue pain medications as needed and his home exercise program. He was again seen on [redacted] and authorization for the viscosupplementation injections was still pending.

An operative report by ***** *****, M.D. at ***** Surgical Center dated [redacted] notes that the patient underwent the following procedures on that date:

1. Diagnostic arthroscopy left shoulder.
2. Left shoulder arthroscopic rotator cuff repair.
3. Left shoulder arthroscopic biceps tenodesis.
4. Left shoulder arthroscopic subacromial decompression with acromioplasty.
5. Left shoulder intraarticular synovectomy.
6. Left shoulder intraarticular injection of anesthetic.

The preoperative diagnosis was left shoulder rotator cuff tear. The postoperative diagnoses were:

1. Left shoulder rotator cuff tear.
2. Left shoulder biceps tendon tear.
3. Left shoulder subacromial impingement.
4. Left shoulder intraarticular synovitis.

The patient tolerated the procedure well.

On [redacted] Dr. ***** saw the patient for postoperative evaluation regarding the left shoulder. On examination, the left shoulder was in a sling. Cervical spine examination showed tenderness of the left upper trapezius, left paravertebral muscles and midline cervical spine with asymmetric motion loss. The sutures were removed and physical therapy was recommended for the left shoulder twice a week for six weeks. On [redacted] the patient was advised to continue postoperative physical therapy.

Dr. ***** saw the patient again for his right shoulder on [redacted] and noted improvement since the last cortisone injection. He advised him to continue home exercises. He was also seen for his right knee per a separate report of the same date, and authorization was still pending for the viscosupplementation injections.

On [redacted] Dr. ***** saw the patient for his left shoulder and cervical spine. Decreased range of motion of the left shoulder was noted as well as well healed portal scars. Decreased 4/5 strength was also noted and there was tenderness in the subacromial space and lateral deltoid with minimal tenderness of the anterior biceps. Tenderness of the left upper trapezius, left paravertebral muscles and midline cervical spine was noted with asymmetric cervical motion loss. Dr. ***** noted the patient had continued motion loss consistent with postoperative frozen shoulder. Note was made of a recent episode in which he reached with his left upper extremity to grab something that was falling, causing acute worsening pain with a popping sensation. Authorization was requested for an MRI of the left shoulder to evaluate this. Physical therapy and a home exercise program were continued. On [redacted] authorization was still pending for the left shoulder MRI. Physical therapy was continued. On [redacted] he had completed physical therapy for the left shoulder, and was to schedule the authorized left shoulder MRI scan.

There is a Diagnostic Imaging report from ***** ***** Imaging Center of left shoulder x-rays dated [redacted] and a multiplanar multi-sequence MRI of the left shoulder obtained on [redacted] as ordered by Dr. *****. These were interpreted by A. ***** *****, M.D. as follows:

> History/Complaints/Pathology: Left shoulder pain. Decreased ROM. History of left shoulder rotator cuff tear surgery.
>
> Multiplanar, multi-sequence MRI of the left shoulder, [redacted]:
>
> Findings:
>
> 1. Left AC joint arthropathy is seen with moderate inferior beaking at distal tip of the acromion. A linear subacromial fluid collection is seen tracking along the supraspinatus tendon and distally toward the insertion site of the humeral tuberosity with questionable narrowing of the distal subacromial space. There is no evidence of a complete rotator cuff tear or muscular retraction seen. The

subacromial linear fluid collection could be postoperative rather than recurrent partial tear. Clinical confirmation is recommended.

2. Paramagnetic artifact is seen which obscured the humeral tuberosity region and the distal supraspinatus tendon as well as the bicipital groove. There is a questionable small linear fluid density extending toward the subdeltoid region with no complete tear or retraction seen. There is limited visualization of the bicipital groove and the long-head of the biceps tendon caused by the paramagnetic artifact. The best images possible were obtained sing the metallic suppression technique. Mild arthritic changes are noted in the glenohumeral joint with no acute fracture or malalignment.

Impression:

1. Moderate AC joint arthropathy with moderate inferior beaking at the distal tip of the acromion with a small linear subacromial fluid collection tracking toward the distal insertion site of the supraspinatus tendon over the humeral tuberosity, which could be postoperative changes rather than recurrent partial tear. Clinical confirmation is recommended.

2. There is no evidence of a complete rotator cuff tear or muscular retraction seen. See discussion paragraph. Correlative analysis with reent intraoperative findings is suggested.

Left shoulder x-rays ([redacted]):

Prior studies not available for comparison.

Impression:

1. Moderate left AC joint arthropathy with small productive changes seen superiorly. There is moderate inferior beaking of the distal tip of the acromion with suggestion of underlying type II acromion with questionable narrowing of the distal subacromial space.

2. Postoperative changes with three metallic anchoring devices are noted projecting over the humeral head consistent with a history of rotator cuff surgery. There is no acute fracture or significant malalignment.

Dr. ***** saw the patient again on [redacted] for his left shoulder and reviewed the MRI. He requested additional physical therapy and the left shoulder was injected. The patient was advised to continue his home exercise program.

On [redacted] Mr. Doe was seen by ***** *****, M.D. [orthopedic surgery] for a Panel Qualified Medical Examination for injuries sustained at work on [redacted] His complaints at the time of this examination were neck pain, bilateral shoulder pain, right elbow pain, low back pain radiating to the left foot and right knee, left hip pain, and right knee pain and swelling. Note was made of a fractured right clavicle in a motorcycle accident in [redacted] Examination of the cervical spine showed diffuse tenderness in the cervical midline paravertebral region and mid trapezius. Left deltoid strength was 4+/5. Bilateral shoulder examination showed diffuse tenderness and decreased range of motion. Impingement I was trace bilaterally and impingement II was 1+ on the left. Motor strength for flexion, abduction, internal and external rotation was 4+/5 on the left. Elbow and wrist examination as well as hip and ankle examination was normal. There was right greater than left tenderness in the lumbar spine. There was diffuse tenderness of the knees and the patient was status post right arthroscopic surgery. There was minimal right medial joint line tenderness. There was 1+ crepitus in both knees. 1+ tenderness was noted of the right patella. The diagnoses:

1. The patient related cumulative trauma [redacted]
2. History of left hamstring sprain [redacted]
3. History of right knee injury [redacted]
4. History of left shoulder injury [redacted]
5. Right shoulder injury.
6. History of neck and left shoulder injuries [redacted]
7. Thoracic sprain [redacted]
8. History of continuing complaints into his cervical spine.
9. Complaints of pain in the bilateral shoulders.
10. Right elbow complaints.
11. Mid and low back pain.
12. Left hip pain.
13. Right knee pain.

Dr. ***** noted that the patient had shoulder surgery in [redacted] and was therefore not yet at maximum medical improvement. He recommended a series of three Synvisc injections and requested medical records.

Dr. ***** issued a supplemental report dated [redacted] and, after reviewing medical records, recommended that the patent continue with an exercise rehabilitation strengthening program, progressive range of motion and rehabilitation exercises. He stated that the medical records supported the patient having industrial injuries including continuous trauma.

On [redacted] Dr. ***** saw the patient again for his mid back. On examination, there was palpable tenderness over the thoracic paravertebral muscles with spasms and asymmetric motion loss. Abnormal sensation was noted over the lateral and anterior thoracic region to light touch. The patient was considered to be at maximum medical improvement and was to return as needed. A separate report of the same date notes he was also seen for his lumbar spine and right knee on that date and was felt to be at maximum medical improvement for these areas as well. Future care was recommended including possible epidural steroid injections and surgery for the lumbar spine as well as viscosupplementation, cortisone injections and eventual total knee arthroplasty for the right knee.

There is another PR2 from Dr. ***** dated [redacted] noting that Mr. Doe was seen on that date for his left shoulder. Examination remained the same. Authorization was requested for physical therapy to the left shoulder twice a week for six weeks.

On [redacted] Dr. ***** reevaluated the patient. Examination of the cervical spine at that time showed diffuse tenderness in the cervical midline paravertebral region and mid trapezius. There was diffuse tenderness of the shoulders and it was noted that the patient was status post left arthroscopic surgery. Shoulder range of motion was decreased bilaterally. Impingement I was trace bilaterally and impingement II was trace on the left. Motor strength showed flexion was 4+/5 bilaterally and abduction and external rotation were 4+/5 on the left. Lumbar spine examination showed right greater than left tenderness. There was diffuse tenderness of the knees and the patient was status post right arthroscopic surgery. There was minimal medial joint line tenderness bilaterally and 1+ crepitus bilaterally. Radiographs were obtained on that date. The lumbar spine x-rays showed diffuse multilevel degenerative changes. X-rays of the bilateral knees showed mild changes and narrowing more on the right knee.

The doctor noted that the patient had improvement with left shoulder surgery and had considered right shoulder surgery but there were no current plans for this. He also noted that the patient had increasing pain in the left elbow after playing golf in [redacted] and received treatment with aspiration. The patient was considered to have reached

maximum medical improvement. For the cervical spine, he was considered to be a 6% whole person impairment. For the left shoulder, a 7% whole person impairment was calculated and for the right shoulder a 4% whole person impairment was calculated. No ratable industrial pathology was found of the right elbow or left hip. Lumbar spine impairment was calculated at 5% whole person impairment. Regarding the right knee surgery, 4% whole person impairment was noted, and radiographs of the right knee showed diffuse narrowing, with a 3% whole person impairment. The combined whole person impairment was 26%. Mr. Doe was considered to be prophylactically precluded from heavy lifting, repetitive overhead reaching or lifting, forceful pushing, pulling, repetitive bending, squatting, stooping, kneeling or walking on uneven surfaces. He was retired as of [redacted]

Dr. ***** indicated that if the patient had continued or increasing shoulder complaints, an MRI would be warranted prior to any surgery, and further surgery may also be required for the knee including possible knee replacement. A short course of physical therapy, use of ice, medications and injections as well as a knee support were also recommended for increased symptoms. For the cervical spine and shoulders, it was felt that 80% of his pathology was industrially related, and 20% would be present even absent his employment activities with the County of *****. For the lumbar spine, it was felt that 70% of his ratable pathology was on an industrial basis with 30% being present with medical probability even absent his employment with County of *****. For the right knee, 100% of his ratable pathology was on an industrial basis.

Dr. ***** reevaluated the patient for his left shoulder on [redacted] at which time examination showed decreased range of motion and 4/5 strength in all planes. There was tenderness in the subacromial space and lateral deltoid. Minimal tenderness was noted over the biceps anteriorly. Cervical spine examination showed tenderness of the left upper trapezius, left paravertebral muscles and midline cervical spine with asymmetric motion loss. His left subacromial space was injected with cortisone.

A separate PR2 report dated [redacted] by Dr. ***** notes the patient was seen for his right shoulder on that date. Examination showed continued motion loss with a positive Hawkins and Neer impingement test and decreased strength in resisted flexion abduction and external rotation. His right subacromial space was injected with cortisone and he was to continue his home exercise program.

Another PR2 report dated [redacted] by Dr. ***** notes the patient was seen for his low back and right knee on that date. On examination, there was asymmetric motion loss of the lumbar spine with a positive straight leg raise on the left and slight decreased

sensation in the left L5 nerve root distribution. The right knee showed motion loss with positive patellofemoral grins and crepitus on range of motion. 2 well healed portals were noted with tenderness to palpation. The right knee was injected and a home exercise program was continued for his lumbar spine.

The patient returned to Dr. ***** on [redacted] for his right shoulder, at which time the right subacromial space was injected with cortisone. Two separate reports of the same date indicate the left shoulder and right knee were also injected with steroid. He was to continue his home exercise program.

Another PR2 report by Dr. ***** dated [redacted] indicates the patient was seen on that date for left shoulder follow up and reported increasing pain lately. Examination remained unchanged. The left shoulder was injected with steroid and he was to return as needed.

On [redacted] chest x-rays were performed at ***** ***** ***** MRI and Radiology Imaging at the request of ***** *****, NP. These were interpreted by ***** *****, M.D. as follows:

> History: Respiratory infection.
>
> [Comparison not reported.]
>
> Findings: There is an area of consolidation posteriorly at the left base, may reflect pneumonia given the history. Follow up study to radiograph resolution recommended to exclude underlying neoplasm. Cardiac silhouette within normal limits. Mild degenerative changes in the T spine.

Chest x-rays were ordered by ***** *****, NP and was performed on [redacted] at ***** ***** ***** MRI and Radiology Imaging. These were interpreted by ***** *****, M.D. as follows:

> History: Coughing, pneumonia.
>
> Comparison: [redacted]
>
> Findings: Cardiac size within normal limits, the aortic arch is unremarkable. There is patchy density within the lower lungs, greater on the left consistent with

pneumonia. Slight blunting of the left costophrenic angle is seen. There is degenerative change of the dorsal spine, with scoliosis convex to the left.

Impression:

1. Increased markings in both lower lungs, greater on the left consistent with patchy pneumonia. Blunting of the left costophrenic angle is seen. Increased markings within the lower lungs appear to have increased, compared to the examination of [redacted]
2. Degenerative change of the dorsal spine, with scoliosis convex to the right.

Volume II of a deposition of ***** *****, M.D. taken on [redacted] is reviewed. [Volume I was not available for review and volume II begins on page 60 and ends on page 110.] Dr. ***** stated he had seen the patient twice, the last being on [redacted]. Note was made that when the doctor examined Mr. Doe on [redacted] there was mention of some crepitus of the left knee and minimal pain. Dr. ***** stated that he did not feel the left knee was compensable and noted that the Guides provided a 2% whole person impairment for pain and crepitus if there is direct trauma, but direct trauma was not defined in the Guides. He therefore deferred to the Trier of Fact. He further stated that if the continuous trauma claim was amended to include the left knee, then there would be a 2% impairment rating, and would probably apportion 70% to industrial and 30% to nonindustrial.

Dr. ***** then discussed his impairment ratings for the cervical spine, lumbar spine and thoracic spine and stated that without other information provided such as an EMG or a reexam, he would not be able to change anything. He also felt the thoracic spine was subsumed within the lumbar spine and did not rate them separately, and his left hip pain also was part of the radiating pain from the back. There was discussion about different ways to rate the right knee, and the doctor stated he would not change his rating of 7% which he felt was accurate. He noted that the patient was retired and therefore he was not having complaints from working. He stated that activities of daily living were used to determine his impairment. The doctor also noted that he considered Mr. Doe able to work up until he retired even though he had injuries but not severe ones. The deposition was then stopped, to resume with a volume III.

Chest x-rays were ordered by ***** *****, NP and was performed on [redacted] at ***** ***** ***** MRI and Radiology Imaging. These were interpreted by ***** *****, M.D. as follows:

History: Pneumonia for three months.

Comparison: [redacted]

Findings: Cardiac size within normal limits, the aortic arch is mildly elongated. Blunting of the left costophrenic angle is noted. Slight increased markings in the left lower lung, could represent minor atelectasis or residual scarring. There is improved aeration of the right lower lung, compared to the prior exam. There are degenerative changes of the dorsal spine, with slight scoliosis convex to the right. There are orthopedic anchors in the left humeral head.

Impression:

1. Atherosclerosis.
2. Blunting of the left costophrenic angle, not changed significantly since the exam of [redacted]
3. There is slight increased markings in the left lower lung, which could represent atelectasis or scarring. There is improved aeration of the right lower lung, compared to the previous examination.
4. There are degenerative changes of the dorsal spine, with scoliosis convex to the right.
5. There are orthopedic anchors within the left humeral head.

The patient returned to Dr. ***** on [redacted] for his left shoulder injury. On examination, there was a mildly positive Hawkins and Neer impingement sign. Examination of the cervical spine showed tenderness of the left upper trapezius, left paravertebral muscles and midline cervical spine. Asymmetric loss of motion was noted with pain on right and left rotation over the left upper trapezius and cervical paravertebral muscles. Dr. ***** recommended continued observation and home exercise program.

A separate report by Dr. ***** dated [redacted] notes the patient was seen for follow up of his right knee pain on that date. Examination showed a small effusion and definite crepitus on passive range of motion. There was a positive patellofemoral grind with apprehension. Another cortisone injection was administered and authorization was requested for Viscosupplementation injections for the right knee.

Another separate report by Dr. ***** dated [redacted] notes the patient was seen for follow up of his right shoulder pain. Examination showed decreased range of motion and 4/5 strength in flexion and abduction. There was a positive Hawkins and Neer

impingement sign as well as positive O'Brien's test. The subacromial space was tender as was the long head of the biceps. Tenderness and spasm was noted of the right trapezius. As the patient had failed to respond to nonsurgical management, the doctor recommended right shoulder arthroscopic rotator cuff repair and authorization was requested. The right shoulder was injected with cortisone and he was advised to continue his home exercise program.

On [redacted] an EMG and nerve conduction studies of the lumbar spine and lower extremities was performed at ***** ***** Medical Center [redacted] M.D. Impression:

1. No electrodiagnostic evidence of bilateral active lumbar sacral radiculopathy of the muscles and nerves tested.
2. No electrodiagnostic evidence of peripheral polyneuropathy of the muscles and nerves tested.
3. Clinical impressions of:
   a. Low back pain with radiation down BLE likely 2/2 spinal stenosis and facet arthropathy.
      i. MRI of lumbar spine 3/2016: 1) Levoscoliosis. 2) L3-L3 3 mm disc bulge extending laterally into both neural foraminal, greater on the left, narrowing the left neural foramen and impinging upon the left exiting nerve roots. 3) L4-L5 3-4 mm broad based disc bulge, greater laterally, with disc material extending into both neural foramina. Facet arthropathy and hypertrophy, mild central canal and moderately bilateral foraminal stenosis, greater on the right, impinging upon the exiting nerve roots bilaterally.
   b. BLE spasms.

Dr. Ngo recommended outpatient PT/OT for low back pain with bilateral leg spasms, and continue current medications and care with the referring provider.

In a supplemental report by Dr. ***** dated [redacted] the doctor reviewed medical records and agreed with Dr. ***** regarding industrial causation for the thoracic/lumbar spine and right knee and impairment. However, the patient continued to experience right knee pain and Dr. ***** stated that additional 8% impairment should be added to the for the right knee due to 2 mm remaining joint space of the tibiofemoral compartment, totaling 13% whole person impairment.

A 63-page remote videoconference deposition transcript of John Doe taken on [redacted] is reviewed. Mr. Doe stated he was hired by County of ***** as a firefighter in [redacted] and retired in [redacted] He also worked some movie set jobs as a safety advisor between [redacted] and [redacted] years on the job. Prior to working for County of *****, he worked or [redacted] County from [redacted] to [redacted] and recalled three work related injuries while working for them, one was metal shavings in his eyes, and he also injured his right ankle and suffered bumps or scrapes.

Mr. Doe stated he stopped working for County of ***** in [redacted] due to injuries to his back, right knee and both shoulders and took regular service retirement, and he then moved to [redacted] Regarding his orthopedic injuries, he stated his doctor was ***** *****, M.D. and his internist in California was Dr. *****. He noted that he had last seen Dr. ***** in [redacted] when he had cortisone injections to his right knee and right shoulder. Mr. Doe also stated that he had seen other orthopedists including Dr. ***** and Dr. *****. He indicated that he was in [redacted] and had back pain for which he bought Flexeril. He also stated that he was currently taking Flexeril or ibuprofen for his right knee but also sometimes his low back and right shoulder. There were three pending unresolved claims for injuries, the first being [redacted] when he injured his neck and left shoulder. He had surgery to his left shoulder on [redacted] and three surgeries to his right knee, the most recent being in [redacted] by Dr. *****. Mr. Doe stated he first noted low back pain in [redacted] after lifting a heavy body and it never went away but waxed and waned over the years including after a structure fire in [redacted] and reaching for his gear in [redacted].

The patient testified that he saw a chiropractor, Dr. [redacted], in ***** ***** two months ago for his back, which helped. He stated that Dr. ***** recommended right shoulder surgery which he would undergo if approved. Also mentioned were motorcycle accidents with a right palm injury in one accident, and a broken right collarbone and broken thumb in another. He also injured his right calf when falling off a ladder in [redacted] or [redacted] while working on his boat.

Mr. Doe stated that since retiring, he gave up riding his motorcycle and spent his time mostly relaxing. He indicated he avoided lifting over 20 pounds because his shoulder and back pain would go into spasms. He noted that he continued to see Dr. [redacted] for his mid and low back which has helped. He also had difficulty bending over, kneeling and squatting due to symptoms in both knees, mainly the right. He was able to walk a half mile without feeling discomfort. Sitting longer than 20 minutes caused his back and right knee to stiffen. He has been told he has arthritis in his right knee and both shoulders. Reaching with his right shoulder caused pain.

A PR2 report by Dr. ***** indicates the patient was reevaluated on [redacted] for his right knee symptoms. He last had a cortisone injection on [redacted] and wanted another one. Examination showed a small effusion. There was definite crepitus on passive range of motion. Positive patellofemoral grind was noted with apprehension. A cortisone injection was administered to the right knee. Dr. ***** still recommended a series of Viscosupplementation injections which had been denied and the doctor requested an appeal for reconsideration.

DIAGNOSES:

1. Cervical myofascial strain superimposed on C5-6 spondylosis without findings of radiculopathy.

2. Status post left shoulder rotator cuff repair and subacromial decompression, [redacted]

3. Subacromial impingement, right shoulder.

4. Lumbar myofascial strain without findings of radiculopathy.

5. Status post multiple right knee surgeries with residual anterior lateral rotatory instability and early medial compartment degeneration.

6. Compensatory pain, left knee.

SUMMARY OF FINDINGS:

Mr. Doe presents for orthopedic evaluation of complaints involving his neck, bilateral shoulders, mid back, low back and bilateral knees that he attributes to his employment as a firefighter for the ***** County Fire Department.

He states he began having back pain around [redacted] noting this was due to constant lifting, pulling, carrying, bending and squatting. He also attributes the back pain to lifting and states he does not recall but he thinks it was a patient. He states he was seen for the injury but does not recall what treatment he received but notes the injury pain was ongoing.

There are no records available to indicate that he had a specific injury to his back around [redacted]

Of note, the available records indicate he had x-rays of his lumbar spine on [redacted] and the lumbar spine x-rays were interpreted as normal.

Mr. Doe indicates that he began his employment with ***** County Fire Department on [redacted]

There are no records to indicate that he received any treatment to his lumbar spine in [redacted]

He states that in the mid-[redacted] he injured his right knee when he stepped into a hole while fighting a brush fire. He states that after an MRI he was told that he had a torn meniscus and had knee surgery. He states he was off work for approximately two weeks and thinks he may have had approximately two weeks of physical therapy. He states he recovered from that injury.

Mr. Doe states that approximately three years later he reinjured his right knee when he stepped off a curb while fighting a structure fire at night. He states that after an MRI he was told that he re-tore his meniscus, and had a second surgery to his right knee. He states he may have been off work for three weeks to one month afterward, and also received physical therapy. He states he recovered from that injury.

There were no records available for review regarding the right knee injuries in the mid-[redacted].

Mr. Doe states he was lifting a patient [redacted] when he injured his thoracic and lumbar spine. He states that x-ray and an MRI were done and he was treated with pain medication and six chiropractic treatments, with benefit.

On review of the records, a Doctor's First Report dated [redacted] indicates he was seen for low back pain, though had no recollection of any direct trauma to his lower back. It was noted that x-rays of his back showed some lipping of the L2 vertebra and he was diagnosed with lumbar paraspinal muscle spasm. He was treated with Motrin, Vicodin and Flexeril, and he was advised not to lift.

X-rays of the lumbosacral spine on [redacted] were interpreted as revealing minimal degenerative changes of the lumbar spine. The findings indicated minimal osteophyte formation at the L2-3 level.

Mr. Doe reports having strained his low back in [redacted] when he was lifting a patient from a toilet to a gurney, though does not recall the treatment he received from that incident.

He recalls having injured his right shin in [redacted] when he was stepping off a fire engine and was off worked for approximately two weeks. He states he returned to work but that injury did not resolve.

He states that in [redacted] he was trying hold up a 300 pound male who had fainted and he injured his lower back. He states he was off work for approximately two weeks after that incident.

Mr. Doe states he strained his left hamstring when he was pulling a three inch supply hose for a structure fire in [redacted] was treated with therapy and was off work for approximately one month. He states that x-rays were taken, and he was told there was small tear in his hamstring. He states he still has scar tissue from that injury that has not resolved.

He also states that in [redacted] he tripped and fell against a door jamb injuring his mid back. He states he reported that incident and continued working.

Mr. Doe states that he reached over to grab an object and felt a pop on his right ribcage in [redacted] He states he went to the hospital but does not recall the treatment he received from that incident.

He states that in [redacted] he was using bolt cutters and heard a pop in his left ribcage. He states he reported that incident but did not receive treatment.

Mr. Doe states that in [redacted] he injured his left hip when he was pulling a hose during a structure fire. He states he reported that incident but did not receive treatment.

Review of the records indicates that he was seen at the emergency department of ***** ***** Hospital on [redacted] because of a right lower leg injury. He states he was diagnosed with a soft tissue contusion and discharged home. He also had an

ultrasound venous duplex study of the right lower extremity at that time that reportedly showed no evidence of deep vein thrombosis.

Mr. Doe states that he was lifting a 300+ pound male from a bed and down a staircase in [redacted] when he injured the right side of his lower back. He states that he reported that incident but did not receive treatment.

He states that in [redacted] he injured his neck, right shoulder and scapula while performing a drill at the fire station. He states he reported that incident but did not receive treatment. He also states that since that incident he still has pain in his neck and right shoulder, along with numbness in his back.

He states that he injured his left ribs when he tripped and fell on top of a fire truck in [redacted] He states he went to County Hospital where x-rays were taken that were reportedly unclear. He states he was told to rest and take ibuprofen, and was off work for three weeks after that incident.

Mr. Doe states he injured his right knee when he was jumping off a hose rack at a fire station in [redacted] He states that after an MRI he was told that he tore his meniscus, and underwent a third surgery to his right knee. He also reports having had physical therapy following the surgery. He states he was able to return to work after the surgery but the surgery did not relieve the pain or his range of motion.

On review of the available records, a Doctor's First Report dated [redacted] indicates he was jumping off the hose drying rack on [redacted] and had right knee pain. He also reported left shoulder pain, noting he had been working with heavy hoses on [redacted] when he had pain in the front of his left shoulder. It was noted that he had prior meniscal injuries to this knee. The diagnosis was right knee pain and he was referred for orthopedic surgery evaluation and treatment, and x-rays and an MRI of the right knee were ordered.

Another Doctor's First Report, dated [redacted] indicates the diagnosis was pain in joint of left shoulder. He was to have an orthopedic surgery referral as well as x-rays and MRI of the left shoulder.

X-rays of the right knee on [redacted] showed faint chondrocalcinosis.

X-rays of the left shoulder on [redacted] were interpreted as unremarkable.

An MRI of the right knee on [redacted] was interpreted as revealing a posterior horn medial meniscus tear and focal chondromalacia changes of the lateral patella facet, in addition to small joint effusion.

An MRI of the left shoulder on [redacted] was interpreted as revealing thickened distal supraspinatus tendon with findings consistent with tendonosis, and probable partial thickness undersurface tear, as well as mild hypertrophic change of the acromioclavicular joint and lateral down sloping of the acromion, placing him at increased risk for anatomic impingement.

An orthopedic evaluation report dated [redacted] notes he jumped off a hose on [redacted] and had an antalgic gait on the right. The impression was right knee pain, recurrent medial meniscus tear, chondromalacia with chondral calcinosis, early osteoarthritis of the medial compartment patellofemoral joint, and status post-operative arthroscopy with medial meniscectomy in the distant past times two. He was recommended arthroscopic surgery with revision partial medial meniscectomy, chondroplasty and debridement.

An orthopedic report dated [redacted] injury notes he was complaining of left shoulder pain with mild crepitus. The impression was minimally symptomatic partial cuff tear, left shoulder. Observation was recommended with no specific limitations.

A report dated [redacted] notes he was seen preoperatively for right knee arthroscopy.

An operative report dated [redacted] indicates he underwent surgical arthroscopy of the right knee with partial medial meniscectomy, partial lateral meniscectomy, and chondroplasty of the medial patellofemoral compartments.

Subsequent treating records indicate he was started on physical therapy post-operatively.

X-rays of the left hip and pelvis on [redacted] showed mild degenerative changes of both hips.

A subsequent record dated [redacted] indicates his soft tissue hip pain had resolved.

A [redacted] record indicates he had six of eight treatments of physical therapy following right knee surgery.

An orthopedic evaluation report dated [redacted] indicates he was seen for work related injuries on [redacted] and [redacted] as well as a CT from [redacted] The diagnoses were left rotator cuff tendonitis and impingement syndrome with probable partial thickness rotator cuff tear. Status post right knee arthroscopy with arthroscopic partial medial and lateral meniscectomy and chondroplasty, [redacted] Chronic lumbar spine strain. Chronic lumbar radicular syndrome. History of left hamstring injury. It was noted that he had not yet reached maximum medical improvement at that time and was recommended right knee post-operative therapy as well as an MRI of the lumbar spine.

At the time of his deposition on [redacted] he stated that he had been involved a motor vehicle accident in approximately [redacted] when he was rear ended while stopped, and did not seek medical attention for that accident. He also had another motor vehicle accident when he was seven years old but denied injury from that accident. He reported having a motorcycle accident in [redacted] when he hit a patch of oil and scraped his right hand. It was noted that he had lost approximately a month from work because he could not grip. He reported having another motorcycle accident in [redacted] when he was thrown off after hitting a berm and suffered injury to the right arm and right shoulder/collar bone. He was seen at the hospital and noted to have a fractured collar bone, and lost approximately one month from work. He also stated that he had surgery to his right thumb involving a pin. He additionally stated that he fell about three feet off a ladder at home and injured his right leg in approximately [redacted]

Mr. Doe testified that he had been hospitalized for leakage from his first knee surgery at ***** *****. He testified to having two work related injuries to his right knee in the mid to [redacted] s resulting in two right knee surgeries.

He testified that he was off work for at least a month with a mid-thoracic injury between approximately [redacted] after lifting a 600 pound patient. He stated that at that time he was seen at the hospital and was treated by a physician.

Mr. Doe also reported having a right ankle injury on [redacted] while climbing down the side of an embankment.

He testified that on [redacted] he lifted a heavy gurney injuring his low back and was seen at the hospital.

He stated that on [redacted] he was jogging when his foot went into a hole in the ground causing injury to his right knee and hip. He testified that on [redacted] he lifted a patient onto a gurney from a toilet and strained his low back.

Mr. Doe testified that on [redacted] he was pulling a hose and injured his left hamstring.

He stated that on [redacted] he injured his left upper back while doing physical therapy.

Mr. Doe stated he hurt his left hip while pulling a hose on [redacted]

He stated that he injured his low back while moving a large patient on [redacted]

He stated that he had injured his neck and right shoulder on [redacted]

Mr. Doe testified that he jumped off a hose rack on [redacted] and injured his right knee, and two days later injured his left shoulder while pulling and twisting a hose.

He stated he had arthroscopic surgery to his knee.

An Orthopedic Agreed Panel Qualified Medical Evaluation Report dated [redacted] indicates he was seen for continuous trauma from [redacted] He had complaints of pain in both shoulders, thoracic spine, lumbar spine, left hamstring and right knee. Diagnoses were listed for the lumbar spine and right knee. The Agreed Medical Examiner indicated there was cumulative trauma pertaining to the back and right knee with reasonable degree of medical probability. It was noted that on questioning the patient there was a note made of right shoulder injury the previous night while handling power tools. MRIs of the thoracic and lumbar spine, and MR arthrogram of the right knee were requested. He was to continue working without restriction.

An MRI of the thoracic spine on [redacted] was interpreted as revealing dextroscoliosis of the upper thoracic spine and levoscoliosis of the lower thoracic spine. Also noted were degenerative changes from T9-10 through T11-12, and a 2 mm right paracentral disc protrusion at T6-7.

An MRI of the lumbar spine on [redacted] was interpreted as revealing levoscoliosis, and a 3 mm disc bulge at L3-4 extending to both neuroforamina, greater on the left, with narrowing of the left neuroforamen and impingement upon the left exiting

nerve roots. Also noted was a 3-4 mm disc bulge at L4-5 with disc material extending to both neuroforamina, with mild central canal and moderate bilateral foraminal stenosis, right greater than left, impinging upon the exiting nerve roots bilaterally.

An MRI arthrogram of the right knee on [redacted] was interpreted as revealing a small middle third and posterior horn of the medial meniscus with an irregular shape likely related to previous surgery as well as what was suspected to be an area of maceration or post-operative changes at the junction of the middle and posterior third of the medial meniscectomy. There was truncation of the free edge of the middle third of the lateral meniscus which was likely due to previous surgery. Also noted was near full thickness cartilage defect in the medial facet of the patella that had progressed since the previous study. Generalized chondromalacia of the medial and lateral compartments was also noted.

An MRI of the right shoulder on [redacted] was interpreted as revealing findings consistent with tendonosis and partial tearing of the rotator cuff, findings suspicious for tear of the anterior superior glenoid labrum, and moderate hypertrophic changes of the acromioclavicular joint with downsloping acromion that may contribute to clinical impingement syndrome.

A report dated [redacted] indicates the right shoulder had been accepted as a work related condition. It was noted that he had been having problems with his right shoulder. He was to complete post-operative therapy for the right knee. An MRI of the lumbar spine was requested authorization.

A supplemental report by the Orthopedic Agreed Panel Qualified Medical Evaluator dated [redacted] notes there is 8% whole person impairment for the thoracic spine, 12% whole person impairment for the lumbar spine with 2% add-on for pain, and 4% whole person impairment for the right knee with 1% for pain. The right knee was apportioned 10% to the [redacted] injury and 90% to cumulative trauma. It was noted that future medical care included epidural steroid injections, Viscosupplementation and/or cortisone injections, medications and possibly total knee arthroplasty.

An orthopedic surgery report dated [redacted] notes he had injuries to the shoulders, left hamstring, back and right knee. There was mention of another injury on [redacted] when he was pulling roofing material after a fire and injured his right shoulder. Diagnoses were listed for both shoulders, lumbar spine and right knee. He was considered a candidate for platelet rich plasma injections for the right knee. An MRI of the left shoulder was recommended, and he was prescribed medications.

According to his history, Mr. Doe states that in [redacted] he injured his neck and left shoulder while pulling a hose and roofing materials during a structure fire. He states that he received treatment, repair of a torn biceps and rotator cuff. He states that he had physical therapy, approximately 16 sessions after that incident. He states the surgery and physical therapy helped but he still had pain and discomfort in his neck and left shoulder.

On review of the records, a progress report dated [redacted] indicates he was seen for pain in the lumbar spine, bilateral shoulders and right knee. He was given platelet rich plasma injection to the right knee. An MRI of the left shoulder was noted to be pending.

An MRI of the cervical spine on [redacted] was interpreted as showing mild degenerative disc changes in the mid thoracic spine, a 3 mm broad based disc protrusion at C5-6 causing mild spinal canal stenosis and possible slight cord compression with associated bilateral moderate foraminal encroachment. Also noted was disc bulging at C6-7 with mild spinal stenosis.

A left shoulder arthrogram on [redacted] was interpreted as revealing moderate to high grade partial thickness articular surface tear of the supraspinatus tendon, type II acromion with lateral down sloping and a 6 mm subacromial enthesophyte. Partial thickness articular surface tear of the infraspinatus tendon was also noted, as well as mild osteoarthritis of the acromioclavicular joint, in addition to mild fluid of the subacromial/subdeltoid bursa.

An orthopedic reevaluation report dated [redacted] notes he was seen for his lumbar spine and right knee. It was noted that the platelet rich plasma injection had helped and was still helping. A series of five Supartz injections for the right knee was requested.

According to his history, Mr. Doe states that in [redacted] he injured his thoracic spine during training, and received treatment but does not recall the treatment he received.

He states he received 8-10 cortisone injections to his right knee, four injections to his left shoulder, 5-6 injections to the right shoulder, and one injection to his left knee. He also reports having received a round of three plasma injections to his right knee.

An operative report dated [redacted] notes the procedures were diagnostic arthroscopy of the left shoulder with rotator cuff repair, biceps tenodesis, subacromial decompression with acromioplasty, and intraarticular synovectomy.

Physical therapy was recommended for the left shoulder when seen post-operatively on [redacted]

On [redacted] he was seen for his right shoulder and noted to have improvement since the last cortisone injection.

The treating orthopedist on [redacted] for the cervical spine and left shoulder noted there was decreased strength in the left shoulder and motion loss consistent with post-operative frozen shoulder. An MRI of the left shoulder was requested and he was continued on physical therapy and a home exercise program.

An MRI of the left shoulder on [redacted] was interpreted as revealing moderate right acromioclavicular joint arthropathy. There was no evidence of complete rotator cuff tear or muscular retraction.

Left shoulder x-rays at that time were interpreted as showing moderate left acromioclavicular joint arthropathy and post-operative changes.

When seen by the treating orthopedist on [redacted] additional physical therapy for the left shoulder was requested and an injection was administered to the left shoulder.

An Orthopedic Panel Qualified Medical Examination Report dated [redacted] notes he was complaining of pain in his neck, bilateral shoulder pain, right elbow pain, low back pain radiating to the left foot and right knee, left hip pain and right knee pain and swelling. It was noted he had shoulder surgery in [redacted] and was not yet at maximum medical improvement. A series of three Synvisc injections was recommended.

A Panel Qualified Medical Examiner Supplemental Report dated [redacted] notes records were reviewed and he was recommended an exercise rehabilitation strengthening program with progressive range of motion and rehabilitation exercises. It was stated the medical records supported he had sustained industrial injuries including continuous trauma.

A report by the treating orthopedic surgeon dated [redacted] indicates he was seen for his back and was considered to be at maximum medical improvement.

Another report by the treating orthopedist dated [redacted] indicates he was seen for the lumbar spine and right knee and felt to be at maximum medical improvement, with

future medical care including possible epidural steroid injections, and lumbar spine surgery as well as Viscosupplementation, cortisone injections and eventual total knee arthroplasty for the right knee.

On [redacted] the treating orthopedist recommended physical therapy for the left shoulder.

A Panel Qualified Medical Examiner Reevaluation Report dated [redacted] indicates x-rays of the lumbar spine at that time revealed multilevel degenerative changes. X-rays of the bilateral knees showed mild changes and narrowing of the right knee. The cervical spine was found to have 6% whole person impairment. The left shoulder was found to have 7% whole person impairment, and the right shoulder 4% whole person impairment. There was no ratable industrial pathology for the right elbow and left hip. The lumbar spine was found to have 5% whole person impairment. The right knee was noted to have 4% whole person impairment for the surgery and 3% whole person impairment for diffuse narrowing on radiographs. It was noted there was 26% whole person impairment.

The cervical spine and shoulders were apportioned 80% industrial and 20% was noted to be present absent employment activities. For the lumbar spine there was 70% ratable pathology on an industrial basis and 30% absent his employment. The right knee was 100% apportioned on an industrial basis.

He was given prophylactic preclusions from heavy lifting, repetitive overhead reaching and lifting, forceful pushing, pulling, repetitive bending, squatting and stooping, as well as walking on uneven surfaces. It was noted that he retired as of March 2017. Future medical care was addressed.

When seen by the treating orthopedist on [redacted] he was provided a cortisone injection to the left subacromial space.

A progress report dated [redacted] indicates he received a cortisone injection to the right subacromial space.

On [redacted] the right knee was injected.

He returned to the treating orthopedist on [redacted] and was given a cortisone injection to the right subacromial space. On that date he also received a steroid injection to his left shoulder and the right knee.

On [redacted] he received a left shoulder steroid injection.

At the time of the deposition of the Panel Qualified Medical Examiner on [redacted] Volume II, he stated that if the continuous trauma claim was amended to include the left knee there would be 2% whole person impairment for pain and crepitus if there is direct trauma but direct trauma was not defined in the Guides, and therefore, deferred to the Trier of Fact. He stated that he felt the thoracic spine was subsumed within the lumbar spine and did not rate them separately. He felt the left hip pain was part of the radiating pain from the back.

The Panel Qualified Medical Examiner justified that he considered Mr. Doe able to work, up until when he retired, even though he had injuries, but not severe ones.

A record by the treating orthopedist dated [redacted] notes the left shoulder was recommended continued observation, and a home exercise program.

Also on [redacted] the treating physician administered a cortisone injection to the right knee and advised him to continue with his home exercise program.

He was also seen for the right shoulder by the treating orthopedist on [redacted] and was noted to have positive impingement signs and positive O'Brien's test. It was noted that if he failed to respond to nonsurgical management, right shoulder arthroscopic rotator cuff repair would be requested. A cortisone injection was given to the right shoulder.

An EMG and nerve conduction studies of the lumbar spine and lower extremities on [redacted] showed no electrodiagnostic evidence of lumbar radiculopathy. He was recommended physical therapy for his low back with bilateral leg spasms.

A treating orthopedist's supplemental report dated [redacted] indicates he reviewed the Agreed Medical Examiner's records for the thoracic/lumbar spine and right knee, and he continued to experience right knee pain. The orthopedist added an additional 8% impairment for the right knee due to 2 mm remaining joint space of the tibiofemoral compartment, totaling 13% whole person impairment.

At the time of Mr. Doe's deposition on [redacted] he stated that he had been hired in 1981 and retired in [redacted]. He recalled having injured his right ankle while previously working for [redacted] County from [redacted]

He testified that he stopped working for the County of ***** in [redacted] due to injuries to his back, right knee and both shoulders, and took a regular service retirement.

He testified that he had seen the treating orthopedist in [redacted] and had a cortisone injection in his right knee and right shoulder. He stated he was currently taking Flexeril or ibuprofen for his right knee and also sometimes for his low back and right shoulder.

Mr. Doe testified that there were three pending unresolved claims for injury. He stated the first was [redacted] when he injured his neck and left shoulder and had left shoulder surgery on [redacted] He stated he had three surgeries to his right knee, the most recent in [redacted]. He stated he first noted low back pain in [redacted] after a lifting a heavy body, and it never went away but waxed and waned over the years, including after a structure fire in [redacted] and while reaching for his gear in [redacted]

He mentioned having seen a chiropractor two months prior for his back, which helped.

Mr. Doe also testified that his treating orthopedist had recommended right shoulder surgery which he indicated he would have if it was approved.

He testified there were motorcycle accidents with a right palm injury in one accident, and a broken right collar bone and broken thumb in another.

Mr. Doe also stated that he injured his right calf when he fell off a ladder in [redacted] while working on his boat.

He stated that since he had retired he had given up riding his motorcycle.

Mr. Doe testified that he avoided lifting over 20 pounds because his shoulder and back would go into spasms. He stated that he continued to see his chiropractor for his mid and low back, which had helped. He mentioned having difficulty bending over, kneeling and squatting due to his symptoms in both knees, mainly the right knee. He stated that sitting longer than 20 minutes caused his back and right knee to stiffen. He also stated that he had been told that he has arthritis in his right knee and both shoulders. He mentioned that reaching with his right shoulder caused pain.

A progress report by the treating orthopedist dated [redacted] indicates he was seen for right knee symptoms. He was given a cortisone injection to his right knee. A series

of Viscosupplementation injections were still recommended and there was an appeal for the denial.

NECK:

He complains of neck pain, frequently. He also reports intermittent numbness and tingling in the bilateral arms, hands and fingers.

Examination of the cervical spine reveals suboccipital and paracervical tenderness extending into the trapezius muscles with moderate muscle spasm on palpation of the trapezius regions bilaterally. There is muscle guarding with range of motion of the cervical spine. Spurling's sign is negative, as is foraminal compression test, and motor, sensory and reflex examinations of the upper extremities are all normal, ruling out cervical radiculopathy clinically.

Current x-rays of the cervical spine demonstrate moderate C5-6 degenerative disc disease, likely mild C6-7 degenerative disc disease, and straightening of cervical lordosis.

The findings are supportive of cervical myofascial strain superimposed on C5-6 spondylosis without findings of radiculopathy.

The cervical spine is stable and requires no treatment at this time.

The cervical spine does not require any formal restriction.

BILATERAL SHOULDERS:

He complains of pain in both shoulders, intermittently, right greater than left. He notes increased pain in his shoulders with activities, including reaching overhead.

Examination of the left shoulder reveals multiple healed arthroscopic incisions. There is faint subacromial crepitus with circumduction of the left shoulder. Impingement signs are negative at the left shoulder. O'Brien's test is negative, apprehension sign is negative and there is no deltoid muscle atrophy of the left shoulder.

X-rays of the left shoulder reveal evidence of rotator cuff repair, including stabilizing suture anchors. There is no evidence for significant acromioclavicular joint osteoarthritis at the left shoulder.

Examination of the right shoulder shows mild deltoid muscle atrophy. There is anterior subacromial tenderness to palpation of the right shoulder. Neer and Hawkins impingement signs are positive at the right shoulder. O'Brien's test is mildly positive at the right shoulder.

Current x-rays of the right shoulder show mild acromioclavicular joint osteoarthritis.

The findings are supportive of status post left shoulder rotator cuff repair with subacromial decompression, [redacted]

The findings are also supportive of subacromial impingement of the right shoulder.

The bilateral shoulders are stable and do not require any treatment at this time.

Referable to both shoulders he is restricted from repetitive overhead work.

MID BACK:

He reports mid back pain, frequently, that radiates to the right shoulder and chest. He also reports numbness to his mid back.

Examination of the thoracic spine shows no scoliosis. There is no palpable tenderness of the thoracic spine. There is no scapulothoracic crepitus or pain, and no winging of the scapulae.

There are no findings to support injury to the thoracic spine based on physical examination.

It would appear that the mid back complaints are emanating from the right shoulder.

LOW BACK:

He complains of low back pain, constantly that varies in intensity and radiates into the left hip, buttock, leg and foot, and also radiates into the right hip, buttock, leg and knee. He also reports numbness and tingling in the left leg, foot and toes, and weakness in both legs.

Examination of the lumbar spine reveals tenderness to palpation from L3 to L5 along the paravertebral muscles. Straight leg raising sign is negative bilaterally, and motor, sensory and reflex examinations of the lower extremities are all normal, ruling out lumbar radiculopathy clinically.

Current x-rays of the lumbar spine demonstrate no significant abnormality. The finding indicate the lumbar lordosis is straightened.

The findings are supportive of lumbar myofascial strain without findings of radiculopathy.

The lumbar spine does not require a formal restriction.

BILATERAL KNEES:

He complains of pain in both knees, right worse than left that increases with a number of activities. He states that he limps intermittently due to right knee pain.

On examination is observed to ambulate with a slightly antalgic gait on the right. There is increased Q angle of the knees bilaterally. He is able to perform two-thirds of a deep knee bend, with difficulty.

Examination of the right knee reveals multiple healed arthroscopic incisions. Anterior drawer sign is mildly positive. Lachman's test is mildly positive at the right knee. There is mild medial and lateral joint line tenderness to palpation of the right knee. There is right sided quadriceps atrophy.

Current x-rays of the right knee demonstrate mild medial compartment osteoarthritis.

Examination of the left knee reveals mild medial and lateral joint line tenderness. Otherwise, orthopedic testing of the left knee is unremarkable.

Current x-rays of the left knee show no significant abnormality.

The findings are supportive of status post multiple right knee surgeries with residual anterolateral rotatory instability and early medial compartment degeneration.

The findings are also supportive of compensatory left knee pain.

Referable to the right knee he cannot walk on hilly or uneven terrain.

CAUSATION:

The current right knee condition is work related.

The current left shoulder condition is work related.

The current right shoulder condition is work related, compensatory for the left shoulder.

Referable to the lumbar spine, although Dr. ***** attributes the back to work injury [redacted] years ago; however, I see no convincing evidence. Dr. ***** notes continuing trauma to the lower back, which is possible.

WORK RESTRICTIONS:

For the bilateral shoulders he is unable to perform repetitive overhead work due to the bilateral shoulder problems.

He cannot walk on hilly or uneven terrain secondary to his right knee condition.

TREATMENT OPTIONS:

Treatment options which could improve his condition consist of wearing a stabilizing brace for the right knee.

NONINDUSTRIAL EVENTS:

At the time of his deposition on [redacted] Mr. Doe testified that he was jogging on [redacted] when his foot went into a hole in the ground causing injury to his right knee. However, there are no medical records to indicate any significant injury to the right knee as a result of the [redacted] incident. It is unclear as to whether the [redacted] incident occurred while jogging as part of his general fitness required of his job, or on a nonindustrial basis.

The [redacted] report by the Orthopedic Agreed Panel Qualified Medical Evaluator indicates on questioning there was note made of right shoulder injury "last night" while handling power tools. At the time of his deposition on [redacted] Mr. Doe testified that there was a right shoulder and neck injury on [redacted]

However, there are no records available for review regarding an injury to the right shoulder on [redacted] or any records pertaining to a right shoulder injury while handling power tools on [redacted] There was mention in the report dated [redacted] that he had been having problems with his right shoulder, which had been accepted as a work related condition. According to his history, Mr. Doe has stated that in [redacted] he injured his right shoulder and scapula when performing a drill at the fire station, he reported the injury but did not receive treatment; however, he states he still has right shoulder pain. He also states that in [redacted] he injured his right shoulder when pulling roofing material from a structural fire. The [redacted] report by his treating orthopedist noted he had another injury on [redacted] when he was pulling some roofing material after a fire and injured his right shoulder. The records indicate he subsequently had an MRI of the right shoulder on [redacted] that showed rotator cuff tendonosis and partial tearing, reflective of injury. The consistent records appear to reflect that at the time of his deposition on [redacted] there was mention of a right shoulder injury on [redacted] which appears to be reflective of his current history of injury to his right shoulder in [redacted] when performing a drill at the fire station, which may have been exacerbated by the handling of power tools the night before he saw the Orthopedic Agreed Panel Qualified Medical Evaluator on [redacted] and likely aggravated by the work related injury on [redacted] when he was pulling some roofing material after a fire and injured his right shoulder and subsequently had an MRI scan of his right shoulder, lacking any treating records to indicate that he had any significant right shoulder injury the night before [redacted]

DISCUSSION OF SERVICE CONNECTED DISABILITY RETIREMENT:

According to the correspondence dated [redacted] the standard for determining a service connected disability retirement as set forth in California Government Code Section 31720 that provides in relevant part: "Any member permanently incapacitated for the performance of duty shall be retired for disability regardless of age if, and only if: The member's incapacity as a result of injury or disease arising out of and in the course of the member's employment, and such employment contributes substantially to such incapacity."

Insofar as incapacity resulting from injury to the left shoulder, and right shoulder on a compensatory basis relating to left shoulder, and as his employment has contributed substantially to the incapacity in the left shoulder, and substantially to the right shoulder, as documented in the records, the bilateral shoulders conditions have arisen out of and in the course of his employment. As he is unable to perform repetitive overhead work duties due to bilateral shoulder problems, and as his employment has contributed

substantially to the incapacity, the incapacity involving his shoulders requiring restrictions has resulted from his employment.

Referable to his right knee, he has had multiple injuries on a work related basis resulting in multiple surgeries, with residual difficulties and inability to walk on hilly or uneven terrain secondary to his right knee. The work related injuries and associated surgeries to his right knee during the course of his employment have contributed substantially to the incapacity involving his right knee.

Should any additional questions arise or additional records be provided, I would be happy to comment further in a supplemental report.

If you have any further questions regarding this patient, please do not hesitate to contact me.

Sincerely,

Richard C. Rosenberg, M.D.

[redacted]

December 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: January 4, 2023 Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
GABOR VARI, M.D. – PSYCHIATRY

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Gabor Vari, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

Gabor Vari, M.D. is Board Certified in Psychiatry. He received his medical degree from University of Pennsylvania and completed his residency at the University of California, Los Angeles. Dr. Vari has 14 years of experience performing independent medical and medical legal evaluations for both public and private organizations.

Upon approval to the panel, LACERA will conduct a virtual orientation with DRS staff, legal counsel and the physician and his management team to provide a comprehensive overview of the LACERA Panel Physician Guidelines, requirements, and protocols to ensure a thorough understanding of the Rules in Evaluating Applicants, Disability Retirement Law Standards, and what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff will also cover report submission timeframes, fee schedule and billing procedures. Additional diagnostic testing request protocols; medical license, Board Certification, and insurance coverage requirements. Lastly, we will provide an overview of the Quality Control Questionnaire process and procedures.

On December 21, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Gabor Vari, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Gabor Vari, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

/TLC

LACERA
Los Angeles County Employees Retirement Association
300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-6132 • 800/786-6464

APPLICATION TO LACERA PANEL OF EXAMINATION PHYSICIANS

ALL APPLICANTS MUST SUBMIT THE FOLLOWING WITH THEIR APPLICATION

- Current Curriculum Vitae
- Two (2) Sample" Medical Reports – Must be Redacted
- Copy of Medical License
- Copy of Board Certification(s) – Applicant must be board certified to qualify for panel
- Certificate of Insurance

GENERAL INFORMATION Please attach a list of any additional locations.	Date 5/23/2022
Physician Name: Gabor Vari MD	Group Name: Click or tap here to enter text.
Primary Address: 865 Via De La Paz #24 Pacific Palisades, CA 90272	
Primary Contact: Gabor Vari	Title: Physician
Telephone: (310) 751-0870 Fax: Click or tap here to enter text.	Email: Gabor@varimd.com
Secondary Address: Click or tap here to enter text.	
Telephone: Click or tap here to enter text. Fax: Click or tap here to enter text.	Email: Click or tap here to enter text.

PHYSICIAN BACKGROUND	
Field of Specialty: Psychiatry Board Certification ☒Yes ☐No	Subspecialty: Click or tap here to enter text. Board Certification ☐Yes ☐ No
License # **A92458** Expiration Date: **8/31/2023**	
Has your license been suspended in the last 3 years? ☐Yes ☒No Has there been any disciplinary actions filed against you in the last 3 year? ☐Yes ☒ No	

EXPERIENCE AND CURRENT PRACTICE
Indicate the number of years of experience that you have in each category and the time spent performing each activity.

Type	Number of Years	Current Practice	Time Spent (%)
AME	14	Treatment	80
IME	14	Evaluations	20
QME	14	Research	0
Workers' Compensation Evaluations	14	Teaching	0
Disability Evaluations	14		100 %

Med-Legal Reports	14		

Performing Medical Evaluations for Public Organizations ☒Yes ☐No

Performing Medical Evaluations for Private Organizations ☒Yes ☐No

Please Names of Organizations: **Various employers throughout California including County of Los Angeles, City of Los Angeles, SCIF, CDCR, County of San Bernardino, County of Riverside, etc.**

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

LACERA FEE SCHEDULE	
Physical Exam and Initial Report	$2,015.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Record Review Only and Initial Report	$1,007.50 + Additional Fee for Reviewed Records* (see Review of Record rate)
Psychiatric/Psychological Examination (in office) and Initial Report*	$ 4, 030.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Psychiatric/Psychological Examination (no exam) and Initial Report*	$ 2,015.00 + Additional Fee for Reviewed Records* (see Review of Record rate)
Toxicology and Oncology Examination (in office) and Initial Report*	$ 3,022.50 + Additional Fee for Reviewed Records* (see Review of Record rate)
Toxicology and Oncology Examination (no exam) and Initial Report*	$ 1,511.25 + Additional Fee for Reviewed Records* (see Review of Record rate)
*Review of Records (by Physician)	$ 455.00 per inch (LACERA will pay up to 1 hour of record-review per inch of medical records)
*Review of Records (by Nurse)	$ 75.00 per inch (LACERA will pay up to 1 hour of record-review per inch of medical records)
Supplemental Report	$ 455.00 per hour
Supplemental Report when Panel Physician Guidelines were not followed	No charge
Other Fees	
Administrative Hearing Preparation	$ 455.00 per hour
Depositions	$ 455.00 per hour with 2 hours minimum
Expert Witness in Superior or Appellate Court	$3,500 – Half Day
Expert Witness in Superior or Appellate Court	$7,000 – Full Day

Cancellation Policy and Fees
Please indicate your cancellation policy and any applicable fees.

What is you Cancellation Policy? (Attach policy, if applicable).

At least 48 business hours for Examination
At least 5 business days for Deposition/Hearing

Cancelled Exams that do not adhere to your stated policy: Fee: $ **750**

Cancelled Hearings that do not adhere to your stated policy: Fee: $ **$400/hour reserved**

Name of person completing this form:

Print Name:	Title:
Gabor Vari M.D.	Psychiatrist
Physician Signature: 	Date May 23, 2022

You may attach additional pages if necessary.

Revised: 12/8/21

Gabor Vari MD, Inc
865 Via De La Paz #24
Pacific Palisades, CA 90272
Phone: (310)-751-0870
gabor@varimd.com

Gabor Vari, MD

Board Certified in Psychiatry

*Articulate, Board certified **Psychiatrist** with over 15 years of clinical expertise. Highly experienced in psychopharmacology, mood disorders and post-traumatic stress disorder.*

Education

- **Brown University, Providence, RI**
  Bachelor of Science with Honors, Biology
- **University of Pennsylvania School of Medicine, Philadelphia, PA**
  Doctor of Medicine
- **University of California – Los Angeles, Los Angeles, CA**
  Residency – Psychiatry

Professional Experience

- **Gabor Vari MD** — **Los Angeles, CA**
  Psychiatrist — *June 2008 - Present*
  Providing psychotherapeutic and psychopharmacalogic treatment to adults in a private practice setting

- **California Medical Evaluators** — **Los Angeles, CA**
  Founder and CEO — *June 2010 – January 2022*
  Founded and scaled leading medical-legal evaluation company

Licensure and Certification

- Board Certification: American Board of Psychiatry and Neurology
- Medical License: California
- DEA Licensure
- AHA BLS Certification

HONORS AND AWARDS

- 2-time *Jeopardy!* Champion (Air Dates October 25 – 27, 2011)
- Appel Award, Most Outstanding Student Entering Field of Psychiatry
  University of Pennsylvania School of Medicine
- Co-President, Strecker Psychiatric Society
  University of Pennsylvania School of Medicine
- Measey Scholarship in International Geriatrics (Edinburgh, Scotland)
  University of Pennsylvania School of Medicine
- University of Pennsylvania Summer Research Grant
  University of Pennsylvania School of Medicine
- Sigma Xi Honorary Society
  Brown University

RESEARCH AND PUBLICATIONS

- Weinstock R, Vari G, et al. Back to the Past in California: A Temporary Retreat to a Tarasoff Duty to Warn. Journal of American Academy of Psychiatry and the Law. 34(4): 523-528, 2006.
- Vari G, Beckson M. Escitalopram-Associated Serotonin Toxicity. Journal of Clinical Psychopharmacology 27(2): 229-230, 2007.
- Vari G, Beckson M, et al. "Legal Issues in Inpatient Psychiatry." Principles of Inpatient Psychiatry. Ed. Fred Ovsiew. Philadelphia: Lippincott Williams and Wilkins, 2009. 139-155

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  Doctor of Medicine
- **University of California – Los Angeles, Los Angeles, CA**
  Residency – Psychiatry

Professional Experience

- **Gabor Vari MD** — **Los Angeles, CA**
  Psychiatrist — *June 2008 - Present*
  Providing psychotherapeutic and psychopharmacalogic treatment to adults in a private practice setting

- **California Medical Evaluators** — **Los Angeles, CA**
  Founder and CEO — *June 2010 – January 2022*
  Founded and scaled leading medical-legal evaluation company

Licensure and Certification

- Board Certification: American Board of Psychiatry and Neurology
- Medical License: California
- DEA Licensure
- AHA BLS Certification

HONORS AND AWARDS

- 2-time *Jeopardy!* Champion (Air Dates October 25 – 27, 2011)
- Appel Award, Most Outstanding Student Entering Field of Psychiatry
  University of Pennsylvania School of Medicine
- Co-President, Strecker Psychiatric Society
  University of Pennsylvania School of Medicine
- Measey Scholarship in International Geriatrics (Edinburgh, Scotland)
  University of Pennsylvania School of Medicine
- University of Pennsylvania Summer Research Grant
  University of Pennsylvania School of Medicine
- Sigma Xi Honorary Society
  Brown University

RESEARCH AND PUBLICATIONS

- Weinstock R, Vari G, et al. Back to the Past in California: A Temporary Retreat to a Tarasoff Duty to Warn. Journal of American Academy of Psychiatry and the Law. 34(4): 523-528, 2006.
- Vari G, Beckson M. Escitalopram-Associated Serotonin Toxicity. Journal of Clinical Psychopharmacology 27(2): 229-230, 2007.
- Vari G, Beckson M, et al. "Legal Issues in Inpatient Psychiatry." Principles of Inpatient Psychiatry. Ed. Fred Ovsiew. Philadelphia: Lippincott Williams and Wilkins, 2009. 139-155

Gabor Vari, M.D.

DIPLOMATE AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY
QUALIFIED MEDICAL EVALUATOR

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AGREED MEDICAL EVALUATION IN THE SPECIALTY OF PSYCHIATRY WITH PSYCHIATRIC TESTING

October 30, 2021

[redacted]

Re: [redacted]
Employer:
WCAB No.:
Applicant DOB:
Dates of Injury:
Claim/File No.:
Date of Evaluation:
Place of Evaluation:

Dear Parties:

Pursuant to your authorization, [redacted] underwent an Agreed Medical Evaluation, in the specialty of Psychiatry, on [redacted] at my Los Angeles office. The undersigned acted in the capacity of Agreed Medical Evaluator, in the specialty of Psychiatry.

Dr. Vari conducted the interview, reviewed all records, performed a mental status examination, and formulated the diagnosis, conclusions, and discussion, including the opinion on causation, temporary disability, permanent disability, degree of disability, future care, work restrictions, and apportionment. Testing was administered by Dr. Vari and interpreted by Dr. Vari except for the MMPI which was interpreted by Pearson Assessments. The report was authored and edited by Dr. Vari. All opinions expressed herein are solely the opinions of Dr. Vari.

Prior to the evaluation, the entire medical file made available to the undersigned was fully reviewed. All of the records reviewed were instrumental in this evaluator arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality) and that any information provided, as well as the results of the psychological testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. Prior to the evaluation, the applicant was advised of the right to ask questions and the right to end the evaluation based on good cause pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

If the applicant wishes to review this report, he or she should only review it under the supervision of a therapist or psychiatrist because the report may be easily misinterpreted by the applicant. This psychiatric report is confidential and privileged. Some individuals and family members may misunderstand and/or distort the information in this report. This may result in significant psychological harm to the applicant or may interfere with treatment and recovery from illness.

For individuals with self-destructive or violent tendencies, the consequences of

disclosure of this report may be serious. This report is meant for the use of qualified professionals only and those with the need to know by law. Persons breaching the confidential nature of this report are acting against medical advice and assume any and all risks and liabilities of doing so.

The report qualifies for Procedure Code ML104 as there are "extraordinary circumstances" relating to the medical condition for which this applicant was examined. This code best reflects the time spent and/or the complexity of this evaluation. The best proof in regard to the complexity of this evaluation is the medical/legal report which reflects the complex issues. The issues of complexity are reflected by the following: Multiple body parts are examined; present and prior work history; past medical history; family and social history; a complex psychiatric history; a complex history due to the applicant being a difficult historian; there are complex issues of causation or apportionment; adverse parties have obtained their own complex and conflicting evaluation requiring interpretation.

This is a Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances (ML-104). The following complexity factors apply:

COMPLEXITY FACTORS

☒ (1) Two or more hours of face-to-face time by the physician

☒ (2) Two or more hours of record review by the physician

☐ (3) Two or more hours of medical research by the physician

☒ (4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;

☐ (5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors

☒ (6) Addressing the issue of medical causation

☐ (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body

region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.

☐ (8) For dates of injury before December 31, 2012 where the evaluation occurs on or before June 30, 2013, addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances;

☒ (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.

☐ (10) For dates of injury before December 31, 2012 where the evaluation that occurs on or before June 30, 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

Billed Under ML-104, time spent includes:

1. A psychiatric evaluation which is the primary focus of the medical-legal evaluation.
2. Face-to-face interview with the applicant. **2.25 hours**
3. Review of medical records. **3.50 hours**
4. Preparation, writing and editing of this report. **4.50 hours**
5. Psychological Testing **3.00 hours**

Additional time was spent in administering psychiatric diagnostic testing which will be billed separately under Code 96101, to be paid according to the current fee schedule.

There are extraordinary circumstances related to the medical condition being evaluated. These extraordinary circumstances justify the use of this procedure code, and are as follows:

1. This psychiatric evaluation requires an extraordinary complex, detailed developmental, family, social, and psychiatric history. This level of information is necessary in order to adequately and credibly address essential issues.

2. Psychiatric protocols are required in order to address the issue of permanent work function capacity. These include the evaluation, assessment and analysis of multiple, complex work functions.

3. This psychiatric evaluation necessitates assessment for the presence or absence of exaggeration due to psychiatric disorder or malingering. This process requires complex analysis in order to determine essential issues such as compensability of the claimed injury.

4. In some cases, there are extensive medical records, which are of a highly complex nature, and sometimes contain conflicting information. The review and analysis of these records often requires increased time.

5. Ancillary documentation is sometimes provided, such as personnel records, deposition transcript, job analysis, or other non-medical records, which must be reviewed and analyzed in order to address relevant issues resulting in increased time of records and preparation of report.

IDENTIFYING DATA

Ms. [redacted] is a [redacted] year-old, married, [redacted] woman who resides in a home she owns in [redacted] California with her [redacted] year-old [redacted], and her [redacted] and a [redacted]. Her date of birth is [redacted]. She was brought to the evaluation by medical transport. She is claiming a bilateral finger, hand, wrist, forearm, and elbow injury as well as injury to her psyche stemming from a [redacted] injury.

REVIEW OF FILE

NON-MEDICAL RECORDS:

Agreed Medical Evaluation Letter, signed by [redacted] applicant attorney, dated [redacted].

The applicant had an accepted bilateral finger, hand, wrist, forearm, and elbow injury which occurred when she suffered second degree chemical burns to her hands and fingers while employed as a painter for [redacted] School District.

The customary determinations on causation, diagnosis, temporary and permanent disability, permanent and stationary status, need for future medical treatment, and apportionment were requested.

Cover Letter, signed by [redacted] defense attorney, dated [redacted].

The applicant sustained an admitted injury to her hands on [redacted] while employed as a painter by the [redacted] School District. She was applying a graffiti removal substance and it penetrated through her gloves and burned her hands. She immediately was declared TTD. She returned to modified work in [redacted] with limited use of upper extremities and worked for only a few days. She had been off work ever since. She had treated primarily with Dr. [redacted], a hand specialist.

She had alleged that as the result of the effects of her physical injury, she had sustained psych injury and had become depressed and anxious. She had taken her deposition on [redacted] indicating that she had history of depression on

a couple of occasions beginning in [redacted] She most recently received some marital counseling for 3 months in [redacted].

The issue of injury AOE/COE to the psych was currently in dispute and there was a lack of medical reporting in that regard. The customary determinations on causation, diagnosis, temporary and permanent disability, permanent and stationary status, need for future medical treatment, and apportionment were requested.

Deposition of [redacted] dated [redacted].

The applicant lived in [redacted] California. She had been taking Wellbutrin prescribed by Dr. [redacted], her private physician. She had been seeing Dr. [redacted] since [redacted]. She had been taking Wellbutrin since [redacted]

She started working at [redacted] School District in [redacted]. She first worked as a reading skills development assistant at the second level. She was working with seventh and eighth graders. She did this for [redacted] years. She then held several temporary jobs with the district. Her previous job was eliminated when funds were cut. She was put on the layoff list. She then became a library assistant. She held this position for [redacted] and half years. She then applied for the painter job and became a painter. As a library assistant, she was working part-time, approximately 17 hours. The painter job was a full-time and permanent position. She started working as a painter on [redacted] She had experience doing painting jobs before. She had painted murals, both exterior and interior. Her job duties as a painter at the district included preparing the surface, climbing, painting, staining, and graffiti removal. She was tasked in repairing and repainting, as well as filling holes. She was also working with structural steel. She worked 40 hours a week.

On [redacted] she had 2 different chemicals, the first one was Unfinished Masonry and Brick Graffiti Removal, and the other one was Graffiti Safewipes. Aside from those, she had also used other graffiti removers. When she first worked as a painter, she had online training sessions regarding safety. There was a personal protective equipment locker. She had access to goggles, gloves and Tyvex suits. She had used disposable gloves and MaxiFlex. These gloves were usually used by painters. They were made of plastic and had a tan color. MaxiFlex was made out of rubberized material, like neoprene. It was wrapped halfway around the fingers.

On the day of the injury, she worked with MaxiFlex gloves. She had done graffiti removal 3 times before she was injured. In safety training, glove use was

discussed. She could not recall if graffiti removal was discussed. Up to the time she was injured, she felt that she was wearing appropriate gloves. On the day of injury, she was working with the custodian of [redacted] Junior High removing graffiti. She could not recall if the custodian was wearing gloves. Working there was her first assignment for the day. She was working in the morning at that time. She got the chemicals she needed from the other painter, who was working there. She recalled that she was told to wear gloves before working. She had been using wipes for a few minutes when she felt a problem with it.

When she started to have problems, she felt a burning sensation in both hands. She removed her gloves and she saw that her hands were black. Her hands were slippery and wet. Her palms and the sides of the fingers were black all over. She went to the restroom and flushed her hands with water. The black color did not come off. She then went to her truck and got her first aid kit. She used a burn cream and it gave her a cool feeling. She could see her hands were burned. They were blackened like a mummy and had blisters. She drove for 7 minutes to the main office of her employer and reported the injury to the secretary. However, the secretary did not know what to do so she waited for the other secretary to get off the phone. The applicant was eventually given treatment on that day. She went to [redacted] Occupational and was seen by Dr. [redacted] who and her hands were flushed with water. A burn cream was also applied. Antibiotics were also applied on the burned area. Her hands were then wrapped and she was given medications, such as Tramadol for pain and an antibiotic. She was also given a tetanus shot. She was asked if she could do a grip test. She did and it was painful. She was given gauze, bandages, antibiotic and burn creams. She was then told to drive back to the maintenance yard. She was able to drive at that time. Driving was not included in her restrictions at that time. She was told by the receptionist at the facility that she could drive. At the maintenance yard, her husband was called. She was told to return after a week and she did. She had not returned to work before she went back to Dr. [redacted]. Before she went back, the conditions of her hands stayed the same.

On the second time she was seen by Dr. [redacted], the dressing around her hands was changed. The first time she returned to work after the second visit was on [redacted]. She was placed on modified work at that time. When she returned to work, she was tasked to make binders in the maintenance department. The 3 ring binders were used in site plans. She was putting documents as well as page protectors into binders. Her restrictions at that time were minimal use of the hands. Her modified position was given by her supervisor, who was aware of her restrictions. She did this job for 3 days. During those 3 days, she went to the secretary and complained about her condition. She told the secretary that she could

not do it and her hands were painful. She also told this to her supervisor, but she was only laughed at and told to ask people for other work.

She did find other work which involved stapling transportation requisitions with purchase orders, using her hands. She did this for 15 minutes, and eventually reported to her supervisor that she could not do this anymore. She was then told to sit in a corner and look out the window. She did not finish her work hours that day. She called personnel and reported her condition. She was told to go off work. She returned to work on [redacted] with restrictions of limited use of the hands per Dr. [redacted]. She worked as a homework club and resource math assistant in the special education department. She was placed in this job by the human resource supervisor. She then worked as an instructional aide. She was told that she was released from her probationary period and that she could not return to her painting job anymore. There was a report that she had failed to meet the painter qualifications. She believed that she could not hold a paintbrush at that time. Psychologically, she was relieved that she was not going to return to the painting job. She was currently working as an instructional aide in the special education department. She was also doing the homework club and math assistant job. She was doing fine and she could do her job properly. She was enjoying it as well.

Presently, in her job she minimally used a pen. She used a keyboard or computer very little. She was teaching 7th and 8th graders. When she was working with them, there was a teacher present.

One of the allegations in her case is that she had sustained a psychiatric injury because of the burn. She started to have emotional problems on the day of the injury. This was triggered by watching the chemicals eat through her hands and having them shrivel, atrophy and turn black. She saw this had happened when she was at the doctor's office. She shut down completely and was in shock. She was seen by Dr. [redacted] in July and was given treatment for her emotions. Her complaints at that time included depression, anxiety and crying. At that time, she felt that she did not want to leave the house and she would wake up crying. She was unable to socialize. For the first 3 weeks after the injury, she stayed at home. She felt overwhelmed by responsibilities and this caused her to be anxious. She was unable to ride her bicycle since the accident. She had not practiced yoga since her accident. She would ride her bicycle a lot when going to work previously. She described that she could not hold a paintbrush and could not pull the back brake of a Cannondale Mountain bike. She could not work on murals and do painting jobs.

She was currently being seen by Dr. [redacted], who was prescribing her medications. The doctor also recommended occupational therapy but this was denied. She had 24 sessions already and the doctor was recommending 12 additional sessions, 2 times per week at [redacted] Occupational. This was denied. She noted that it was beneficial. Treatment consisted of ultrasound, paraffin, massage therapy, and the stimulator for building up strength. These were beneficial. She had been doing home exercises, but this was not as beneficial as formal physical therapy.

She denied seeing Dr. [redacted] between the time she was injured and the time Wellbutrin was prescribed.

She had taken Prozac before in [redacted] for depression. This was when she placed a child in an open adoption. She could not recall for how long she received treatment for depression at that time. She was in [redacted] at that time. After 4 months, her depression was resolved. From that point until she was injured, she admitted having mood swings but she did not need medication during that time. She did not believe she was clinically depressed between those times.

Before working at the District, she worked at [redacted] She was a counselor/youth aide for 8 months. She left because she had a baby at that time. She was off work for some time. There were 9 months between her employment at [redacted] and the School District. She recalled that she had unemployment benefits at that time. At the time she was prescribed Prozac in [redacted], she was also in counseling. She could not recall the name of her psychiatrist at that time. She had a good relationship with the child she placed for an open adoption. She recalled that she had some marriage counselling 7 to 9 years prior. In the last couple of years, she denied having other psychological problems other than the one caused by the burn injury.

When she was still living in [redacted] she was being seen by a [redacted] psychologist. She had been in counseling for 3 months. She had separations from her husband, which lasted for 2 weeks. She went to the same doctor when she left Well Spring.

She recalled that another painter was having the same problem with graffiti removal. She was not sure if this was true. She was told of this story on the day she was injured. A maintenance worker in charge of the PPE was given the same gloves she had when she was injured. She was not aware that they had chemical gloves.

In the last 2 years, she could not recall having marital problems. She lived on a tight budget. Her husband stopped working because they had too many children to pay for childcare; he was a stay at home dad.

She recalled that her daughter had an eye injury 4 years prior and it caused her stress.

She had been taking Wellbutrin since [redacted], for almost 2 months. Presently, she had 10 more days' worth of Wellbutrin and she has no primary care physician to go back to because the group medical was cut off on [redacted]. All of the family insurance was lost.

When she took Wellbutrin, she would not cry all day long. She was not as emotional when not taking it. When she had to use her hands and she could not she became emotional. This would make her cry.

She was last seen by Dr. [redacted] on [redacted]. At that time, she was told to continue doing her exercises, as well as taking Voltaren for swelling. She had the same restrictions at that time. She denied using topical creams.

Currently, her right hand was worse than the left. However, in the last couple of months, she felt that her treatment had improved. She continued to have pain in her hands when she was using them. There were no times that she was pain free. The pain was localized around the joints of the hands, all the way up to the elbows.

Dr. [redacted]'s report indicated tendinitis of the forearms. The applicant was not told the cause of it. She was told by her therapist that her tendinitis was caused by her injury. She had numbness and tingling in her hands, more on the tips of the fingers and along the sides of the fingers. She noticed that her hand symptoms had decreased with physical therapy. It included massage therapy.

She had problems with grip and she felt it was related to strength. She was not using her arms and hands very much at this point. She felt that she had atrophy of her hands, and that her pain was interfering with her grip strength.

She was able to eat with a knife and fork, but with difficulty. She also had problems with dropping things. She would drop measuring cups when cooking. She had assistance when cooking. She had lost some sensation so she could not determine how close she was to hot or cold surfaces. She had webbing between her thumb and index finger on the left hand. This was numb.

She admitted that she was a victim of violence. This was when she worked at [redacted]. She had to work with another painter, who degraded her for being a woman more than once. She reported this to the labor representative. This resulted in the applicant working on her own. She started working on [redacted], and she started working on her own the following week.

She denied having any other work-related injuries, personal or bodily injury lawsuits, or car accidents. She had a bicycle accident in [redacted] and broke her left collarbone. She recovered fully. At that time, she was knocked off her bicycle by someone exiting their parked car. Her hospital bills were paid by Medi-Cal. Presently, she could do overhead things without a problem, including yoga.

She denied being in an ER in the last 5 years. She was treated at [redacted] Medical Center for the birth of her 3 children. She had been seeing a gynecologist at [redacted].

She admitted that she was avoiding social situations because of her injury. She used to go out with her friends before she was injured. Her injury also affected her regular volunteering at her children's school. She was not able to do that after her injury.

She was a fine art painter. She painted and sculpted including clay, plaster and metals. She denied doing welding.

She noted triggering symptoms in her hands especially when she would use force. Her fingers would snap into a clawed position. This involved the index, thumb, and the middle fingers. It would happen once a day, particularly when she was turning the faucet.

As a painter at the District, she worked with chemicals including brush cleaner. She would normally use water-based paint.

[redacted] She was trying to look for public transportation for that meeting. The counsel discussed providing transportation for the applicant.

In a normal day, she would do her exercises. She would do a little gardening and take care of her animals. She could water the plants and do light weeding. She wore leather gloves when doing so. She had not gone back to yoga because she did not have the flexion in her hands that was required to do yoga due to hand pain.

She noted that she was a Volunteer [redacted] representative for her [redacted] union until the beginning of [redacted]. She was at their booth at the convention in Sacramento.

She believed that she would benefit from some psychotherapy and counseling at this time.

She admitted having panic attacks. She had previous verbal incidents with her husband 9 years prior. This was resolved.

MEDICAL RECORDS:

Doctor's First Report of Occupational Injury or Illness, signed by [redacted], M.D., dated [redacted]

The applicant sustained injuries to her hands while removing graffiti with some special Graffiti Safewipes. The chemicals went through her gloves and burned her hands as she must have been wearing the wrong gloves. She complained of painful burned hands.

Diagnoses: 1) Chemical burns to the hands and fingers. 2) Contact dermatitis of the hands and fingers. 3) Pain of the hands.

Treatment Rendered: The applicant's hands were rinsed with soap and water. Dressing was applied. Tetanus booster and Gentamycin were administered. Tramadol, Levofloxacin, Silvadene cream, and Procomycin antibiotic cream were dispensed.

Work Status: She was placed on modified work with no lifting, pushing or pulling over 5 pounds and limited use of the hands. No direct contact with hands or fingers to chemicals/paint/solvents was recommended. She must keep the bandages clean and dry.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted].

The applicant was feeling slightly better with her painful burned hands. Diagnoses: 1) Second degree burn hands/wrists. 2) Contact dermatitis. 3) Pain of the limb. Dressing was medicated with Silvadene cream. Procomycin and Silvadene cream was dispensed. She remained on modified work with no lifting, pushing, or pulling over 5 pounds, and limited use of the hands. No direct contact

with hands or fingers to chemicals/paint/solvents was recommended. She must keep the bandages clean and dry.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted].

The applicant had remained the same. She was feeling slightly better concerning her burned hands. Diagnoses: 1) Second degree burn hands/wrists. 2) Contact dermatitis. 3) Pain of the limb. Dressing was medicated with Silvadene cream. Procomycin and Silvadene cream was dispensed. She remained on modified work with no lifting, pushing, or pulling over 5 pounds, and limited use of the hands. No direct contact with hands or fingers to chemicals/paint/solvents was recommended. She must keep the bandages clean and dry.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted].

The applicant was feeling slightly better with regard to her hands. Diagnoses: 1) Second degree burn hands/wrists. 2) Contact dermatitis. 3) Pain of the limb. Dressing was medicated with Adaptic. Procomycin and Silvadene cream was dispensed. She remained on modified work with no lifting, pushing, or pulling over 5 pounds, and limited use of the hands. No direct contact with hands or fingers to chemicals/paint/solvents was recommended. She must keep the bandages clean and dry.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted].

The applicant's hands were slightly better. Diagnoses: 1) Second degree burn hands/wrists. 2) Contact dermatitis. 3) Pain of the limb. Procomycin cream was dispensed. Authorization for occupational therapy twice a week for 3 weeks was requested. She remained on modified work with no lifting, pushing, or pulling over 10 pounds, and limited use of the hands.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted].

The painful burns on the applicant's hands were slightly better. Diagnoses: 1) Second degree burn hands/wrists. 2) Contact dermatitis. 3) Pain of the limb. Procomycin cream was dispensed. Authorization for occupational therapy twice

a week for 3 weeks was requested. She remained on modified work with no lifting, pushing, or pulling over 15 pounds, and limited use of the hands.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was unable to use her hands effectively. She had diminished sensation and lack of strength in her upper extremities. She had difficulty with grasping, tying shoes, bathing, washing dishes, lifting objects, using the stove, and holding a cold cup. Her pain alleviated with rest.

She worked as a full time painter. Her job duties involved picking up gallons of "milk," "washing out," and painting. She was required to have contact with water and use ladders.

Diagnoses: 1) Contact dermatitis and other eczema due to other chemical products. 2) Blisters, epidermal loss of hand, unspecified site. 3) Pain in the limb.

The applicant was provided occupational examination and therapeutic exercise.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Therapeutic exercise and manual therapy were provided.

Occupational Therapy Progress Note, signed by [redacted], O.T.R./L., dated [redacted].

History of Present Illness: The applicant was working on removing graffiti from school walls. She was wearing gloves and using two different types of chemicals to remove the graffiti. A reaction between the gloves and chemicals caused second degree chemical burns on her hands.

She currently had an increase in functional use of her hands.

Plan: Occupational therapy twice a week for 3 weeks was recommended. Therapeutic exercise and manual therapy were provided.

Primary Treating Physician's Progress Report, signed by [redacted], M.D., dated [redacted].

The applicant was feeling slightly better with regard to her hands. Diagnoses: 1) Second degree burn hands/wrists. 2) Contact dermatitis. 3) Pain of the limb. Procomycin cream was dispensed. Authorization for an extension of occupational therapy twice a week for 3 weeks was requested. She remained on modified work with no lifting, pushing, or pulling over 15 pounds, and limited use of the hands.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Therapeutic exercise and manual therapy were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Therapeutic exercise and manual therapy were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Therapeutic exercise and manual therapy were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Therapeutic exercise and manual therapy were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Therapeutic exercise and manual therapy were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Therapeutic exercise and manual therapy were provided.

Primary Treating Physician's Report, signed by [redacted], M.D., dated [redacted].

The applicant continued to experience pain, swelling, and stiffness in the hands radiating to her forearms. She complained of some decreased sensation in the hands as well. She had been off work since the injury.

Diagnoses: 1) Status post chemical burns of the hands. 2) Bilateral forearm, wrist, and hand tendonitis/tenosynovitis.

Treatment Plan: Occupational therapy twice a week for 6 weeks was recommended.

Work Restrictions: She was precluded from heavy, repetitive or forceful use of the hands.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Therapeutic exercise, manual therapy, and ultrasound/phonophoresis were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant attended occupational therapy. She was treated with therapeutic exercise, manual therapy, and ultrasound/phonophoresis.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant presented for occupational therapy. She was provided ultrasound/phonophoresis, therapeutic exercise, manual therapy, and whirlpool.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Ultrasound/phonophoresis, therapeutic exercise, manual therapy, and whirlpool were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Therapeutic exercise, therapeutic kinetic activity, and whirlpool were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted]

The applicant was seen for occupational therapy. Therapeutic exercise, therapeutic kinetic activity, and whirlpool were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Ultrasound/phonophoresis, therapeutic exercise, therapeutic kinetic activity, and whirlpool were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Ultrasound/phonophoresis, therapeutic exercise, therapeutic kinetic activity, and whirlpool were provided.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Ultrasound/phonophoresis, therapeutic exercise, therapeutic kinetic activity, and whirlpool were provided.

Daily Note, signed by [redacted], O.T.R./L., dated J[redacted].

The applicant presented for occupational therapy. She was treated with ultrasound/phonophoresis, therapeutic exercise, therapeutic kinetic activity, and paraffin bath.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant presented for occupational therapy. She was provided ultrasound/phonophoresis, therapeutic exercise, therapeutic kinetic activity, and paraffin bath.

Occupational Therapy Progress Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant complained of triggering thumbs several times a day, especially when turning on the faucet. Occupational therapy twice a week for 6 weeks was recommended.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant was seen for occupational therapy. Ultrasound/phonophoresis, exercise, therapeutic kinetic activity, and paraffin bath were provided.

Primary Treating Physician's Report Request, signed by [redacted], M.D., dated [redacted].

The applicant's hand pain and strength were improving with therapy. She continued to experience some swelling and numbness in the hands. She remained anxious and depressed associated with her industrial injury.

Diagnoses: 1) Status post chemical burns of the hands. 2) Bilateral forearm, wrist, and hand tendinitis/tenosynovitis.

Treatment Plan: Occupational therapy twice a week for 6 weeks, as well as psychological evaluation was recommended. Voltaren 100 mg was prescribed.

Work Restrictions: She was precluded from heavy, repetitive or forceful use of the hands.

Daily Note, signed by [redacted], O.T.R./L., dated [redacted].

The applicant presented for occupational therapy. Ultrasound/phonophoresis, therapeutic exercise, therapeutic kinetic activity, and paraffin bath were provided.

Primary Treating Physician's Progress Report, signed [redacted], M.D., dated [redacted].

The applicant had not received authorization for therapy. She continued to complain of pain, swelling, and intermittent numbness in her hands. She was working light duties.

Diagnoses: 1) Status post chemical burns to both hands. 2) Bilateral forearm, wrists and hand tendinitis/tenosynovitis. 3) Bilateral carpal tunnel syndrome.

Treatment Plan: The applicant was to continue a home exercise program. She should also continue with her NSAID. She would benefit from evaluation and treatment by a psychologist given her anxiety associated with her injury.

Authorization for psychological evaluation was requested.

Work Status: She was to continue her present light duties with restrictions of no heavy lifting and repetitive or forceful use of both hands.

That completes the review of records.

HISTORY OF PRESENT CONDITION AND ALLEGED CIRCUMSTANCES OF INDUSTRIAL STRESS AND STRAIN, (as given by the applicant)

Ms. [redacted] was hired by [redacted] School District in approximately [redacted] She is claiming a bilateral finger, hand, wrist, forearm, and elbow injury as well as injury to her psyche stemming from a [redacted] injury.

After her [redacted] injury she was taken off of work for one month. She returned to work for 3 days and was then taken off of work for 6 months. She returned to work with restrictions and has worked in an alternative work position since [redacted]. She is currently working in this position.

She was initially hired as a [redacted] Assistant II. After [redacted] years she was laid off and filled temporary open positions with the district until she was given a permanent position as a part-time [redacted] Assistant [redacted] years ago. During the time that she worked as a Library Assistant she also taught computer classes and English as a second language classes as well as performing data entry for the school district. On [redacted] she took a position as a Painter, which was a full-time position with benefits. On [redacted], after her injury, she became an Instructional Assistant II. She is currently working in this position.

As a [redacted] she maintained the school district facilities by prepping and painting various buildings and ramps and removing graffiti.

As an [redacted] Assistant II, she assists students in homework club at [redacted] Junior High School in [redacted] This is an alternative work position that she is assigned to indefinitely.

In her job as a [redacted] she worked from 7:00 a.m. to 4:00 p.m., Monday through Friday. As an [redacted] Assistant II, she works from 12:00 p.m. to 3:45 p.m., Monday through Friday. She is currently paid $[redacted] per hour. Her supervisor is the principal, [redacted]. She is in a union.

In addition to working at [redacted] School District, prior to her injury the applicant worked as a freelance face painter and muralist. She worked for friends and family performing face painting at parties a few times a year and also painted one mural per year on average. She made less than $[redacted] per year doing these jobs. She has never been injured performing this work. She denied having any other concurrent work.

She has not had any previous workplace injuries and has never filed any prior workers' compensation claims.

She denied receiving any warnings, write-ups, suspensions, demotions or any other personnel actions.

The applicant received workers' compensation payments of 2/3 of her regular pay during the time she was off of work. She was also compensated for the last 1/3 of her pay with leave and vacation time that she had accumulated. She stopped receiving these payments on [redacted] when she was returned to work as an Instructional Assistant. She did not receive any state disability. She is currently receiving her part-time pay.

On [redacted] the applicant was sent to [redacted] Junior High School to perform graffiti removal with the help of the day custodian of the school. She described that the graffiti covered a large span of wall that was mainly unfinished masonry and the paint used for the graffiti had a phosphorescent agent in it. Because the graffiti was on unfinished masonry, she had to completely remove the paint and could not just paint over it. She had to use two different chemicals to remove the paint. She described that she and the custodian spent 2 to 3 hours removing the graffiti. As she performed the graffiti removal the chemicals she used dissolved through the gloves she had been given to perform the job. She was unaware of this until her lunch break when she went to the bathroom and took off the gloves. As she removed the gloves, she saw that her hands were black and it appeared that the black gloves had melted into her hands. She flushed her hands with water in the bathroom sink and then used the first aid kit in her truck to treat her hands with burn cream. She drove herself to her work yard and reported her injury. She recalled that the person on duty did not know what to do and waited 10 minutes for another person to get off of the phone. This person also did not know what to do and called HR who told him to send the applicant to the doctor. She was taken to the industrial clinic where Dr. [redacted] flushed her hands. Dr. [redacted] then looked up the chemicals that she had been using and treated her for the burns. She believed that he used Silvadene burn cream, as well as an antibiotic cream. Her hands were then completely wrapped in gauze and triple Ace bandages from her fingers to her elbows. She was also given an antibiotic and a tetanus shot. She did not require any hospitalization or skin grafts. The applicant was then asked to perform grip tests and recalled that her grip strength was zero because her hands were wrapped in gauze and bandages. She was released to return to work with modified duty. She recalled asking the doctor if she was safe to drive herself back to work because the bandages were large; she described them as being like "mitts." She was told she could drive and returned to work where she gave her supervisor

her work restrictions. She was sent home by her employer at that time.

Ms. [redacted] remained off of work for one month. She continued to treat with Dr. [redacted] every two weeks. He would check her burns and change her bandages. She was required to change her bandages in between visits. After a month she returned to work to an alternative work position where she was asked to answer phones. She explained to her employer that she was still in the bandages and did not believe that she would be able to pick up the phone to answer it. She was reportedly told that since she had been able to answer her own phone she should be able to answer phones at work. She was unable to answer the phones and was given the task of making binders. She recalled that with the "mitts" on her hands it took her three days to compile 20 of the binders. She was upset and crying because the work was so difficult with her injuries. At the end of the third day her supervisor told her to return the next day and "sit and look out the window." She called HR and told the HR representative that the work was inappropriate and that she was in pain due to the work. She was then taken off of work again.

Dr. [redacted] took her bandages off of the left hand after 4 weeks and off of the right hand after 5 weeks. After the bandages were removed and the lesions had healed, her hands were contracted into "claws" and she could not open them fully. She had tendonitis in her hands. After the bandages were removed Dr. [redacted] referred her to occupational therapy with [redacted]. She attended two sessions a week for 24 sessions. Further therapy sessions were requested and denied; however after her deposition further occupational therapy was approved. She reported that the occupational therapy helped to reduce the swelling in her hands which has helped to improve the range of motion of her hands. It also helped to break up the scar tissue. With therapy she was able to open her hands however she continued to have limitations. In [redacted] she began to use a stimulator, which improved the strength in her hands. Prior to her injury she estimated her grip strength was 65 pounds and it is currently 50 pounds.

In [redacted] she met with her labor representative, her supervisor, and an HR representative. She recalled that in the meeting her supervisor said, "I don't even know if we have chemical gloves on site." She was upset by this because the gloves she had used were the ones she had been trained by her employer to use with the chemicals, and she had trusted that she was given the right safety equipment. She recalled that she realized that her injury was "a big deal" during this meeting. This was when she decided to retain an attorney.

Her attorney referred her to hand specialist Dr. [redacted] who prescribed Voltaren for edema and outlined very specific exercises for her to perform in

occupational therapy. This included placing her hands in paraffin wax, massage therapy, exercises using putty, and vibration therapy as well as BTE exercises and ultrasound treatment. She also has nerve activities to strengthen her nerve response. She believed that this specialized occupational therapy helped her hands to further improve. She was also given home exercises by the occupational therapist to improve the sensation in her hands. She was told to put her hands in rice and then in beans, and then in cotton.

She returned to work in a modified role as an [redacted] Assistant II on [redacted] Her job does not require her to use her hands and she is able to perform the work. None of the activities are repetitive and she is not required to type for more than 5 minutes. This position is part-time and does not include benefits. She was not offered full time work. She spoke with her union about her losing full time work and her union attempted to fight this, however this was unsuccessful. She was told that she was considered an at-will employee when she took the position as [redacted] and nothing could be done. This has been resolved as far as the union and school district are concerned and there is no further plan of action regarding this.

Dr. [redacted] has not released her yet. He believes that she requires further occupational therapy which she has continued with twice weekly. He has not discussed surgery or any other treatment. She described that in the last week she has developed shooting pain from her hands to her wrists when she squeezes her hands closed. She has discussed this with the occupational therapist.

She has not undergone an AME or QME evaluations for her hands.

Ms. [redacted] denied having any psychiatric symptoms immediately prior to her [redacted] injury. She indicated that she was doing well emotionally and enjoyed her job. She reported that her emotional symptoms began when she returned to work one month after her injury and was required to make binders in a modified role. She recalled that at that time she realized the extent of her limitations because she could not perform even this simple task. She recalled that prior to that time she had believed that she would heal quickly, however she began to realize that her recovery would be protracted and that she may never be the same. She became anxious because she was the sole provider for her family. She experienced an overwhelming fear of the future and worried about how she would support her family. She described that she had always done physical work that required her hands in the past and she became anxious that she would not be able to use her hands anymore. She felt sad, experienced low energy, and began to experience frequent crying spells. She experienced depressed mood and did not

want to see or talk to her friends. She was embarrassed and felt that everyone stared at her bandages. She felt useless and worthless when the bandages came off and she realized that she was still unable to bathe, dress or brush her hair without help. When she ran into friends and was asked about her injury, it was hard for her to talk about it. She isolated and stopped volunteering. She resigned from the office she had held in her union chapter prior to her injury. She also held office on the state wide level with the union and took a leave from this position. She was scheduled to speak at a union event, which she cancelled. She had previously enjoyed going to listen to bands and dancing, and she stopped doing this after the injury.

In [redacted] when she met with her union representative and her supervisor, she was upset that her employer may not have provided her with the proper equipment to do her job.

She recalled that in [redacted] she began to sleep "all the time." In the past she had never been a "napper" or able to sleep during the day. Although she was sleeping during the day she was unable to sleep at night. She reported that at times it took her two hours to get to sleep and at other times she could not get to sleep at all. Prior to the injury she slept for 5 to 6 hours, whereas after the injury was sleeping 3 to 5 hours at night and then napping for up to 3 hours during the day. Her concentration and focus was affected and she could not remember things. She described that prior to her injury she could recall the names of 80 students. After the injury she could not even remember the names of the students in her class. She previously enjoyed reading and was able to read quickly. After her injury she would read the same paragraph repeatedly without comprehending it. She became irritable and developed a short temper. She cried or yelled when something small like a dish breaking occurred, and got angry more quickly in general. She reported that prior to her injury she was able to sit with a student "for days" and now she cannot do this for 5 minutes without being frustrated.

She previously had sex once a day or more, however since her injury she has lost interest in sex. This has impacted her marriage and both she and her husband are both on edge. She felt that "everything" was her fault and felt guilty that she was unable to work and for her irritability and disinterest in sex. She turned to food for comfort and gained at least 20 pounds. She currently weighs [redacted] pounds whereas prior to her injury she weighed [redacted] pounds. This is the most she has ever weighed. She denied any hallucinations. She denied any problems with alcohol or drugs.

She attempted to return to her union role in [redacted], but her abilities related to her hands were very restricted and she chose not to be a delegate at a Union conference. She still attended as a guest. She recalled that when she was there she felt overwhelmed and anxious in the crowds. She was having difficulty cutting her food at that time and continued to feel embarrassed about her hands. She was further depressed by this. She became sick with vomiting and diarrhea during the conference and was unsure if this was due to her nerves or food poisoning.

When she began to treat with Dr. [redacted] she reported her emotional symptoms to him. He requested authorization for psychiatric treatment, however this was denied.

In [redacted] as her physical limitations persisted, she felt hopeless and began to experience suicidal ideation every day as she felt that she could not overcome her injuries. She saw her private internal medicine specialist, Dr. [redacted]. [redacted] California. Dr. [redacted] prescribed the antidepressant Wellbutrin, which she found helpful. With this medication she cried less frequently, had more energy, and was no longer napping during the day. She had more desire to do things and felt that she was "trying more." She described that her suicidal ideation diminished from all day every day to fleeting thoughts occurring two to three times a day. She denied ever having a suicidal plan or ever attempting suicide.

She was not referred to a psychiatrist and did not receive any psychotherapy. She is no longer seeing Dr. [redacted] because she no longer has health insurance. She would like to receive mental health treatment.

CURRENT CONDITION

The applicant has pain in her hands that is a constant throb at a severity of 2/10. When she squeezes her hands she experiences shooting pain into her wrists at a severity of 7/10. She has numbness from her fingers to her wrists. She has diminished sensation in the tops of her hands. She has limited flexion in her hands, and her pinky and ring fingers. She has triggering in her thumb, pinky and index fingers. She feels a snapping sensation in her finger joints at times. She has reduced grip strength.

Emotionally, she continues to experiences daily depressed mood, anxiety, insomnia, increased appetite with significant weight gain, irritability, diminished interest in sex, crying spells, low energy, difficulty with focus and concentration, worry about the future, and intermittent suicidal ideation without intent.

CONCURRENT STRESSORS

Ms. [redacted] admitted to having previous financial problems. She filed for bankruptcy in [redacted] After that time she was able to meet her financial obligations although her finances "were tight." Since her injury and inability to work, she has had further financial difficulties and has had to use savings bonds that she had previously set aside for her children. She has not had to file for bankruptcy again since her injury. She has had difficulty paying her bills and indicated that she had received a notice that her water was going to be shut off the day after this evaluation if the bill was not paid. She had never had a disruption of utility services prior to this. She denied any recent repossessions. She is not in collections for any debts.

Her [redacted] had an eye injury when she was [redacted] years old. A chain broke on a playground swing and "popped the globe of her eye." Her [redacted] had to have her retina reattached and her eye rebuilt. She underwent three surgeries and reportedly underwent a month of recovery in which she was in a face down position. Her [redacted] is able to see, however, she requires special contact lenses and ongoing care with an eye doctor bimonthly. She will also require further surgery in future. The applicant did not file a lawsuit regarding this injury. Ms. [redacted] is concerned about her daughter because their health insurance was cancelled as she is no longer working full time. She is unable to get the required ongoing treatment for her [redacted] because of this.

[redacted]

She denied any other medical, behavioral, academic, or drug or alcohol problems for any of her children.

The applicant reported that although she is more irritable and disinterested in sex, her marriage is currently stable. She and her husband previously had marital problems (detailed further below) however their marriage has been stable since they reunited in [redacted] She denied any infidelity and denied any separations since that time. Her husband has not worked for many years because it did not make sense for them financially. She described that if she and her husband were both to work, they would require childcare as well as transportation for the children which would cost more than he would earn. Her four children attend three different schools and are each involved in after school activities. Since her injury, her

husband has been looking for work. He previously worked in construction and has been looking for work in this field. She denied any medical, legal or drug or alcohol problems for her husband.

She denied any recent deaths or familial illnesses. She does not have a third party lawsuit related to this injury and does not have any other legal problems. She denied any arrests. She denied any history of drug or alcohol problems.

CURRENT TREATMENT

She is currently treating with hand specialist Dr. [redacted] and occupational therapist [redacted].

CURRENT ACTIVITIES

The applicant gets up at 5:00 a.m. each morning and cooks breakfast for her son. She sends her son to school on the bus at 5:30 a.m. each day. She then lets the chickens out and feeds and waters the chickens and the dogs. After this, her other children get up and she gets them ready for school and makes breakfast. Her husband takes the children to school. She then walks for exercise for half an hour to an hour each day. When she returns she does her chores including hanging laundry. She gets ready for work and walks the 8 blocks to her job where she works for 3.75 hours. After work, two days a week she walks to the physical therapy facility where she attends therapy for an hour. She walks home from work or her physical therapy appointment each day. When she arrives home she feeds the chickens again.

Her [redacted] and her husband do the laundry and the applicant hangs it on the line, which she has been told to do as therapy by her occupational therapist. She is able to cook now that her hands have improved. She and her husband both do the cooking and her children also help. She cooks most dinners and cooks breakfast. Her husband does the shopping. Her entire family including the applicant clean the house on Saturdays. Her [redacted] does the floors, ceiling and gardening. [redacted], does the collecting and sorting of the laundry and also cleans the bathroom. Her [redacted] cleans the kitchen, and her [redacted] picks up his toys.

The applicant showers and dresses daily. She previously required help to shower, however she is now able to shower independently. She has been able to wash her hair on her own since [redacted] She is also able to use the toilet on her own now

although she previously had difficulty. She is able to dress herself, however she has difficulty tying her shoes.

She is able to drive. She has not driven more than 15 minutes at a time since the accident because her hands become numb. Prior to her injury she rode her bike to work every day which she had done since she graduated from high school. She has not been able to ride her bike to work since her injury because the vibration causes her pain and she cannot pull the hand breaks. She tried to ride her bike to work last week with her occupational therapist's approval. She felt shooting pain in her wrists when she gripped the handles and had pain from the vibration of the bike. The occupational therapist then advised to stop riding her bike for now.

She reads, gardens, and walks for fun. She and her family go to [redacted] football games on Friday nights. They do not go to away games.

She does not attend church, which is normal for her.

Prior to her injury she saw her friends weekly. Since the injury she has seen them once.

She travelled to [redacted] California in [redacted] for a union event. She also went to [redacted] in [redacted] for a union event. She does not have any upcoming travel plans. Her parents are coming to visit her from [redacted] this year.

PAST PSYCHIATRIC HISTORY

Ms. [redacted] experienced depressed mood in [redacted] when she placed a child in an open adoption at that time. She experienced symptoms similar to those she has been experiencing currently, however she denied experiencing any suicidal ideation during that time. She sought mental health treatment and was prescribed Prozac. She could not recall the name of the doctor who prescribed this. Over the course of the "few" months that she took Prozac, her doctor increased her dosage on two occasions. She reported that she then fainted and was subsequently taken off of Prozac and was not prescribed any other medication. She also attended psychotherapy for 5 months. She found this to be helpful and her symptoms resolved after 5 months and she stopped treatment.

After her she and her husband separated in [redacted] she again became depressed. She attended individual psychotherapy with Dr. [redacted] in [redacted] on [redacted] for 6 sessions. She found this helpful and her symptoms resolved. She did not take any psychiatric medications at that time.

She denied any drug or alcohol problems, suicide attempts, or psychiatric hospitalizations.

FAMILY HISTORY

The applicant denied a family history of psychiatric illness, diagnoses, treatment, or hospitalization.

SOCIAL HISTORY

Ms. [redacted] was born and raised in [redacted] She and her [redacted] were raised by both parents. She denied any childhood abuse. She graduated from high school and then graduated from [redacted]. She then moved to [redacted] California for work.

In [redacted] she became pregnant while she was unwed and living in [redacted] She felt that she could not raise a child on her own and placed her son in an open adoption. She was initially depressed when she gave him up, however her depression resolved after approximately 5 months, as described above. She has not continued to feel upset about this and is happy that he has been raised by a good family. She has remained in contact with her son and his adoptive family and he is aware that she is his mother. Her [redacted] in [redacted] and will [redacted]. She plans to attend [redacted]

She has been married once, to her current husband. After they had children, she and her husband decided to move to [redacted] for a better community to raise their children. They bought a historic home there in [redacted] where they have lived since. She and her husband were separated in [redacted] when he was between jobs and there was financial tension in their relationship. He felt that he was a financial drain and moved out of the house for two months to look for work so she would not have to support him. They then reconciled when she got a job.

She and her husband separated again for one week in [redacted] There was an altercation between them with pushing and yelling. She denied any alcohol or drugs being involved. The neighbors called the police who came to their house and asked her what she wanted to do. She reportedly said, "He doesn't need to be here." The police gave her paperwork for a temporary restraining order which was granted for 5 to 7 days. After this brief period, she and her husband reconciled. She reported that her marriage has been stable since that time. There have not

been any further incidents of domestic violence or periods of separation. She denied any infidelity in her marriage.

[redacted]

Her mother suffers from arm pain. She is otherwise healthy and doing well. Her father requires a pacemaker. He is also doing well otherwise. Her parents live in a senior community and have a plan for future care if it is necessary. She is not concerned about her parents' health.

She denied any history of arrests and denied ever having a drug or alcohol problem.

OCCUPATIONAL HISTORY

Prior to working for the school district, she worked for a temporary agency and was placed as a child care worker at a youth ranch for junior high students. She stopped working at this job because she was the sole overnight counselor and was unable to pump breast milk for her infant.

Prior to that she worked for the [redacted]

She has never been fired from a job.

MEDICAL HISTORY

Ms. [redacted] underwent a tonsillectomy when she was 4 or 5 years old. She underwent a tubal ligation in [redacted] She did not have any complications of these procedures.

She broke her collar bone in [redacted] in a bicycle accident. Her injury resolved completely and she denied any permanent impairment related to this.

She denied any other medical conditions, injuries, accidents including car accidents, surgeries or hospitalizations.

CURRENT MEDICATIONS

The applicant is currently taking Bupropion 100 mg bid, and Diclofenac 100 mg once at night.

PSYCHIATRIC DIAGNOSTIC TESTING

BECK ANXIETY INVENTORY: 34- Severe Anxiety

The Beck Anxiety Inventory is a 21-question self-report inventory which asks the applicant to choose from a hierarchy of levels of anxiety-related symptomatology for each question. This is a self-rating device to delineate the nature, intensity and frequency of anxiety-related symptomatology. Each question is scored from zero to three, with a maximum score of 63 for the test. The higher the score, the higher the self-rating by the applicant as a measure of anxiety-related symptoms.

0 – 7	Minimal anxiety
8 – 15	Mild anxiety
16 – 25	Moderate anxiety
26+	**Severe anxiety**

BECK DEPRESSION INVENTORY: 52- Severe Depression

The Beck Depression Inventory (BDI) is a 21-question self-report inventory which asks the applicant to choose from a hierarchy of levels of depressive symptomatology for each question. This is a self-rating device to delineate the nature, intensity and frequency of depressive symptomatology. Each question is scored from zero to three, with maximum score of 63 for the test. The higher the score, the higher self-rating by the applicant as a measure of depressive symptoms.

0 - 9	Minimal depression
10 – 18	Mild depression
19 – 29	Moderate depression
30+	**Severe depression**

HAMILTON PSYCHIATRIC RATING SCALE FOR ANXIETY

15- Mild Anxiety

The Hamilton Rating Scale for Anxiety emphasizes the somatic, or bodily, symptoms of anxiety which include cardiac, respiratory, and gastrointestinal symptoms. Therefore, it is the most objective measure of symptoms of anxiety.

0 – 7	None/Minimal Anxiety
8 – 17	**Mild**
18 – 24	Moderate
25+	Severe

HAMILTON PSYCHIATRIC RATING SCALE FOR DEPRESSION

17- Moderate Depression

The test was developed by Dr. Hamilton, and is not a "self-rating" test. Rather, applicants discuss their responses with the physician who rates their degree of depression and/or anxiety. Both are considered the most objective measure of an applicant's degree of depression and/or anxiety. Scores to determine the degree of depression and anxiety vary by clinician. The Hamilton Rating Scale for Depression is the most commonly-used psychiatric test in psychiatric pharmacologic management and in research studies because of its objectivity. This test emphasizes vegetative depressive symptoms – such as sleep, appetite, and sexual disturbance – in contrast to the Beck Depression Inventory which emphasizes affective, cognitive and vegetative symptoms. The Hamilton Rating Scale for Depression is used extensively to measure clinical improvement in levels of depression, and an antidepressant is considered efficacious if it results in 50% reduction in the applicant's scores on this test.

0 – 7	None/Minimal Depression
8 – 13	Mild
14 – 18	**Moderate**
19 - 22	Severe
23+	Very Severe

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY – 2

PROFILE VALIDITY

Her MMPI-2 clinical profile is probably valid. The client's responses to the MMPI-2 validity items suggest that she cooperated with the evaluation enough to provide useful interpretive information. The resulting clinical profile is an adequate indication of her present personality functioning.

This client's responses to the items that appear near the end of the MMPI-2 were exaggerated in comparison to her responses to items that appear in the beginning of the test. There is a possibility that she responded to the last section of items carelessly, randomly, or deceitfully, thereby invalidating that portion of the test. Although the clinical scales are scored from items

in the first two-thirds of the test, caution should be used in interpreting the content scales and supplementary scales, which include items found throughout the entire item pool.

SYMPTOMATIC PATTERNS

This report was developed using the Hs, D, Hy, and Pd scales as the prototype. Individuals with this MMPI-2 clinical profile tend to exhibit a pattern of chronic psychological maladjustment and frequently have histories of acting-out behavior, including outbursts of anger. This client seems to have a great many vague physical complaints, especially symptoms of tension, insomnia, and stomach distress. In addition, she probably has a history of medical problems, environmental stress such as job or financial troubles, and substance use or abuse difficulties.

Apparently emotionally immature, she is dependent and demanding and tends to become irritable when her demands are frustrated. She may appear suspicious and hostile toward professional staff.

Although she is describing her present problem situation largely in terms of vague physical complaints, her PSY-5 scores suggest some long-term personality characteristics that can influence her adjustment. She tends to view the world in a highly negative manner and usually develops a worst-case scenario to explain events affecting her. She tends to worry to excess and interprets even neutral events as problematic. Her physical complaints might be, in part, a function of her tendency to catastrophize. Her self-critical nature prevents her from viewing relationships in a positive manner. She also shows a meager capacity to experience pleasure in life. Persons with high scores on the INTR (Introversion/Low Positive Emotionality) scale tend to be pessimistic. Her pervasive physical problem presentation could result, in part, from this characteristic personality deficit.

PROFILE FREQUENCY

It is usually valuable in MMPI-2 clinical profile interpretation to consider the relative frequency of a given profile pattern in various settings. The client's MMPI-2 high-point clinical scale score (Hy) was found in 10.5% of the MMPI-2 normative sample of women. However, only 3.7% of the sample had Hy as the peak score at or above a T score of 65, and only 2.1% had well-defined Hy spikes. This elevated MMPI-2 profile type (2-3/3-2) is very rare in samples of normals, occurring in less than 1% of the MMPI-

2 normative sample of women.

The relative frequency of this profile in various outpatient settings is informative. In the Pearson female outpatient sample, this MMPI-2 high-point clinical scale score (Hy) was the second most frequent peak, occurring in 17.2% of the women. Moreover, 13.3% of the outpatient women had the Hy scale spike at or above a T score of 65, and 7.5% had well-defined Hy peaks. This elevated MMPI-2 profile configuration (2-3/3-2) was found in 5.8% of the women in the Pearson outpatient sample.

PROFILE STABILITY

The relative elevation of her clinical scale scores suggests that her profile is not as well defined as many other profiles. There was no difference between the profile type used to develop the present report (involving Hs, D, Hy, and Pd) and the next highest scale in the profile code. Therefore, behavioral elements related to elevations on Pt should be considered as well. For example, intensification of anxiety, negative self-image, and unproductive rumination could be important in her symptom pattern.

INTERPERSONAL RELATIONS

She appears to be rather dependent, demanding, and manipulative in interpersonal relationships, and she may act aggressively if frustrated. She may have a tendency to be verbally abusive toward her husband when she feels frustrated.

She is somewhat shy, with some social concerns and inhibitions. She is a bit hypersensitive about what others think of her and may have concerns about her relationships with others. She appears to be somewhat inhibited in personal relationships and social situations, and she may have some difficulty expressing her feelings toward others.

Her very high score on the Marital Distress Scale suggests that her marital situation is quite problematic at this time. She reported a number of problems with her marriage that are possibly important to understanding her current psychological symptoms.

DIAGNOSTIC CONSIDERATIONS

Individuals with this profile often have a long-standing Personality

Disorder, with substance use or abuse as a prominent feature of their clinical pattern. They may also show elements of an Anxiety or Depressive Disorder.

TREATMENT CONSIDERATIONS

The client's long-term personality problems will probably influence treatment efforts. Antagonistic behavior may be expected in the early stages of treatment. Psychotherapy with such clients may be a long and difficult process because they tend to resist psychological interpretations and view their problems as physical. Because these individuals typically have difficulties controlling anger, they usually experience relationship problems that need to be dealt with in therapy. They also tend to blame others for their problems and see no need for personal change. Major, long-term personality changes are not likely to occur. Treatment that is focused on symptom relief without confronting major personality problems may have some success. Family evaluation and/or treatment may need to focus upon her potential to act out aggressively against other family members.

Her hostile manner of interacting with others may carry over into treatment, reducing the likelihood of therapeutic gain. Individuals with this personality style are not very receptive to suggestions from others.

MENTAL STATUS EXAMINATION

The applicant is a [redacted] year-old [redacted] woman who appears her chronological age. She was well groomed for the interview. She was dressed casually in a long knit skirt and black blouse. She appeared overweight. She walked with a normal gait and maintained a reasonable pace as we walked between the waiting area and the examination room. She fidgeted at times with her hands during the interview.

The applicant was cooperative, attentive, and maintained good eye contact during the course of the interview. She was a moderate historian. She had some difficulty remembering specific dates as well as the chronological order of some events. However, she was able to recall a reasonable amount of detail for her current condition as well as her past history. Her speech was spontaneous and fluent. There was no evidence of dysarthria. Her speech was of normal rate, volume, and tone in general. Her thought process was linear. Her thought content was significant for passive suicidal ideation without intent or plan. There was no homicidal ideation nor were there auditory or visual hallucinations. There was

generally no evidence of any psychosis. Her affect was somewhat restricted throughout the interview. There were periods of tearfulness when she was discussing the loss of use of her hands and her depressed mood. She was well related overall, however she did appear dysphoric. In terms of mood she described herself as feeling depressed and anxious. She was oriented times four. Memory, focus, and concentration were grossly intact. General information skills appear to fall in the average sphere of vocabulary and use of language and conversation. Her insight appears intact and her judgment appears intact as well.

DIAGNOSIS (DSM-IV-TR)

Axis I	Clinical Psychiatric Syndrome and Other Conditions:
296.32	Major Depressive Disorder, Recurrent, Moderate
300.02	Generalized Anxiety Disorder
Axis II	Personality and Specific Developmental Disorders:
V71.09	No Diagnosis
Axis III	Description of Physical Disorders:
	Deferred to the appropriate medical specialists.
Axis IV	Severity of Psychosocial Stressors.
	Occupational, and financial stressors.
Axis V	CURRENT GAF: 56 with corresponding WPI of 21

Explanation of GAF Ratings:

91-100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
81 – 90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71 – 80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational or general functioning (e.g. temporarily falling behind in school work).

61 – 70 Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functions (e.g. occasional truancy, or theft within the household) but generally functioning pretty well, has some meaningful interpersonal relationships.

51 – 60 Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or coworkers).

41 – 50 Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).

31 – 40 Some impairments in reality testing or communications (e.g., speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relationship, judgment, thinking, or mood (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant in home and is failing at school).

21 – 30 Behavior is considerably influenced by delusions or hallucinations OR serious impairments in communication or judgment (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day, no job, home or friends).

11 – 20 Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent; manic excitement) OR occasionally fails to main minimal personal hygiene (e.g. smears feces) OR gross impairment in communication (e.g. largely incoherent or mute).

1 – 10	Persistent dangerous of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

LEVELS OF PERMANENT MENTAL IMPAIRMENT

As identified in Table 14-1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

Class 1. No Impairment
Class 2. Mild Permanent Impairment
Class 3. Moderate Permanent Impairment
Class 4. Marked Permanent Impairment
Class 5. Extreme Permanent Impairment
D Deferred until MMI

1. Activities of Daily Living

D	Self-care personal hygiene (urinating, defecating, brushing teeth, combing hair, dressing oneself, bathing, eating, preparing meals, and feeding oneself)
D	Communication (writing, typing, seeing, hearing, speaking)
D	Physical activity (standing, sitting, reclining, walking, climbing stairs)
D	Travel (driving, riding, flying)
D	Nonspecialized hand activities (grasping, lifting, tactile discrimination)
D	Sexual function (orgasm, ejaculation, lubrication, erection)
D	Sleep (restful, nocturnal sleep pattern)

2. Social Functioning

D	Gets along well with others
D	Initiates social contacts
D	Communicates clearly with others
D	Interacts and actively participates in group activities
D	Cooperative behavior, consideration of others, and awareness of others' sensitivities
D	Interacts appropriately with the general public
D	Asks simple questions or requests assistance
D	Accepts instructions and responds appropriately to criticism from supervisors
D	Gets along with coworkers and peers without distracting them or exhibiting behavioral extremes
D	Maintains socially appropriate behavior
D	Adheres to basic standards of neatness and cleanliness

3. Memory, Concentration, Persistence, and Pace

D	Comprehends, Persistence, and Pace
D	Works with or near others without being distracted
D	Sustains and ordinary routine without special supervision
D	Ability to carry out detailed instructions
D	Maintains attention and concentration for specific tasks
D	Makes simple work-related decisions
D	Performs activities within a given schedule
D	Maintains regular attendance and is punctual within customary tolerances
D	Completes a normal workday and workweek without interruptions from psychologically based symptoms

4. Deterioration or Decompensation in Complex or Work Life Settings (Adaptation to Stressful Circumstances)

D	Withdraws from the situation or experiences exacerbation of signs and symptoms of mental disorder
D	Decompensates and has difficulty maintaining performance of activities of daily living (ADL's,) continuing social relationships, or completing tasks
D	Able to make good autonomous decisions/exercises good judgment
D	Performs activities on schedule
D	Interacts appropriately with supervisors and peers
D	Responds appropriately to changes in work settings
D	Aware of normal hazards and takes appropriate precautions
D	Able to use public transportation and can travel to and within unfamiliar places
D	Sets realistic goals
D	Makes plans independent of others

OVERALL PERMANENT IMPAIRMENT RATING: Deferred until MMI

DISCUSSION

Summary of Issues:

Ms. [redacted] is a [redacted] year-old, [redacted] woman who was hired by [redacted] School District in approximately [redacted] She is claiming a bilateral finger, hand, wrist, forearm, and elbow injury as well as injury to her psyche stemming from a March [redacted] injury.

Summary of Reported Injury:

On [redacted] the applicant used two different chemicals to remove paint from a wall at [redacted] Junior High School. The chemicals dissolved through the gloves and burned her hands. When she realized this, she flushed her hands and used the first aid kit in her truck. She went back to the work yard and was sent for treatment to Dr. [redacted] Her hands were treated and then wrapped in gauze and triple Ace bandages from her fingers to her elbows. She was released to return to work with modified duty, however her employer sent her home.

She remained off of work for one month and continued to treat with Dr. [redacted] every two weeks. After one month she returned to an alternative job position, however she was unable to perform the work due to the bandages on her hands. She was taken off of work again.

Dr. [redacted] took her bandages off of the left hand after 4 weeks and off of the right after 5 weeks. Her hands were contracted and she could not open them. Dr. [redacted] referred her to occupational therapy with [redacted] which she attended twice a week for 24 sessions. Further physical therapy sessions were denied; however after her deposition further occupational therapy was approved. With therapy she was able to open her hands, however she continued to have limitations.

In [redacted] after a meeting with her labor representative, her supervisor, and an HR representative, she realized the gravity of her injuries and retained an attorney. She was referred to hand specialist Dr. [redacted] who outlined specific exercises for her occupational therapy. Dr. [redacted] also prescribed Voltaren for edema.

She returned to work part time in a modified role as an Instructional Assistant II on [redacted] She was not offered full time work. She spoke with her union about this and her union attempted to fight it but was unsuccessful.

Dr. [redacted] has not released her yet. He believes that she requires further occupational therapy which she has continued to attend twice weekly. Her hands have further improved with treatment, however in the last week she has developed shooting pain from her hands to her wrists when she squeezes her hands closed. Dr. [redacted] has not discussed surgery or any other treatment.

She has not undergone any AME or QME evaluations.

Summary of Reported Symptoms:

Ms. [redacted] indicated that prior to her [redacted] injury, she was psychiatrically asymptomatic. She reported that her emotional symptoms began one month after her injury when she returned to work briefly and could not perform the tasks she was given. She realized the extent of her injuries and limitations at that time. She began to experience depressed mood, anxiety, worry about the future, embarrassment about her injuries and limitations, low energy, and crying spells. She felt useless and worthless when the bandages came off and she was still unable to bathe, dress or brush her hair without help. She felt overwhelmed and anxious in the crowds and embarrassed about her hands. She began to isolate, stopped volunteering, and resigned from her position in her union chapter.

In [redacted] when she met with her union representative and her supervisor, she was upset that her employer may not have provided her with the proper equipment to do her job.

In [redacted] she had difficulty getting to sleep and staying asleep at night and then would sleep during the day. Prior to the injury she slept for 5 to 6 hours, whereas after the injury she was sleeping 3 to 5 hours at night and then napping for up to 3 hours during the day. She experienced difficulty with focus and concentration, irritability, feelings of guilt, and lost interest in sex. Her appetite increased and she gained at least 20 pounds. She denied any hallucinations. She denied any problems with alcohol or drugs.

She reported her emotional symptoms to Dr. [redacted] who requested authorization for psychiatric treatment, however this was denied.

In [redacted] as her physical limitations persisted, she felt hopeless and began to experience suicidal ideation every day, all day.

Summary of Treatment:

In [redacted] as she developed suicidal ideation, she sought treatment through her private insurance with internal medicine specialist, Dr. [redacted] She was prescribed the antidepressant Wellbutrin. She found this beneficial as she cried less frequently, had more energy, and was no longer napping during the day. She had more desire to do things and her suicidal ideation lessened to fleeting thoughts occurring two to three times a day. She denied ever having a suicidal plan or ever attempting suicide.

She has not received any mental health treatment through workers' compensation. She is no longer receiving treatment from Dr. [redacted] because she no longer has health insurance.

Currently, she continues to experiences daily depressed mood, anxiety, insomnia, increased appetite with significant weight gain, irritability, diminished interest in sex, crying spells, low energy, difficulty with focus and concentration, worry about the future, and intermittent suicidal ideation without intent.

Summary of Past Psychiatric / Psychological Treatment:

Ms. [redacted] experienced depressed mood in [redacted] when she placed a child in an open adoption. She sought mental health treatment and was prescribed Prozac and attended psychotherapy for 5 months. She found this to be helpful and she stopped treatment after 5 months when her symptoms resolved.

She again became depressed in [redacted] when she and her husband separated. She attended individual psychotherapy with Dr. [redacted] and again had a resolution of symptoms. She was not experiencing any psychiatric symptoms immediately prior to her industrial injury.

Summary of Outside Stressors:

Ms. [redacted] admitted to previous financial problems including a [redacted] bankruptcy. She indicated that immediately prior to her injury although finances were tight, she and her husband were able to meet their financial obligations. She has had financial problems since she has been unable to work as she is the sole provider for her family. Her husband is a stay-at home father which was a decision that they made jointly years ago as it was most financially feasible for them.

Her [redacted] ago and requires ongoing care from an eye specialist. The applicant was not concerned about this at the time of

her injury as she had health insurance through her job. She is concerned about her daughter presently because her health insurance was canceled since she is no longer working full time.

Her [redacted] has had some difficulty transitioning to the first grade and attends speech therapy. The applicant indicated that these are minor issues and do not concern her.

The applicant admitted to previous marital problems and brief separations in [redacted] and [redacted] as well as one incident of domestic violence in [redacted] after which she obtained a one week temporary restraining order. According to the applicant after reuniting in [redacted] their marriage has been stable and they have not had any further problems. Her marriage was stable and not a source of stress at the time she was injured.

Discussion of Records Reviewed:

In her deposition dated [redacted] her report of her previous psychiatric history was consistent with what she reported during this evaluation. She indicated that she took Prozac for depression in [redacted] related to giving her son up for an open adoption. Consistent with her report to me she indicated that her symptoms resolved after a brief period. She reported on deposition that she was not clinically depressed between that time and her injury. She did testify to seeking counseling 7 to 9 years previously as well as seeing a psychologist due to marital conflict, consistent with her report to me. She indicated during my evaluation that she had again become depressed in [redacted] due to these marital problems and that these symptoms had subsequently resolved after six sessions of therapy without need for any medication. On deposition she reported domestic violence issues with her husband in the past, consistent with her report during this evaluation. She denied having any current marital problems on deposition which is also consistent with her report during this evaluation.

The applicant testified to developing depression, anxiety, crying, isolating, and feeling overwhelmed and anxious subsequent to her industrial injury. She testified to having panic attacks also, although she was not specific as to what symptoms she had; she did not report any panic attacks during this evaluation. She testified that she received Wellbutrin from Dr. [redacted] and indicated a diminishing of symptoms including not being as emotional and crying less frequently. This is consistent with her report to me.
I noted that on deposition she reported that she had previously been the victim of physical violence while working at [redacted] She

elaborated that a coworker degraded her for being a woman which she reported to the labor representative. She indicated that she worked with this individual for one week and then was no longer required to work with him. This appears to have been a brief work conflict and there is no indication that she was experiencing any ongoing emotional difficulties related to this.

The earliest treatment record that I received was a record of the industrial injury dated [redacted] from Dr. [redacted] I did not receive any records from prior to the injury. Dr. [redacted] diagnosed her with chemical burns to her hands and fingers at that time.

The first report of psychiatric symptoms was a [redacted] report from Dr. [redacted] which noted she "remained anxious and depressed associated with her industrial injury." Her symptoms were again noted in his [redacted] report. Consistent with her report during this evaluation, it does appear that he repeatedly requested a psychological evaluation.

I did not receive any records from her primary care physician Dr. [redacted]

Discussion of Psychological Testing:

Self-reported Beck inventories for both anxiety and depression indicated a severe level of symptoms. More consistent with my overall clinical impression, clinician-rated Hamilton scale assessments were in the moderate range for depression and in the mild range for anxiety.

Her MMI-2 profile was valid although it did also suggest the possibility of some exaggeration or carelessness. Her profile suggested she has physical complaints as well as excessive worry, irritability, and a meager capacity to experience pleasure in life. This is consistent with her report to me. Her profile suggested she is dependent and hypersensitive with some social concerns and inhibitions. The applicant admitted this to be the case since her injury, however she denied this being a natural state of being for her and described herself as quite social and independent prior to her injury. Her profile suggested possible marital distress and that she may have a tendency to be verbally abusive to her husband. The applicant did report that since her injury she has become more irritable and less interested in sex than she had been previously. Despite this, she denied any current marital problems. Her profile suggested substance use or abuse as a possible prominent feature of her clinical pattern. The applicant specifically denied ever having any drug or alcohol problem and there was no evidence in the records to dispute this. Her profile suggested a possible personality disorder, however I do not find that

the dependent traits noted in this profile are part of a long term personality disorder as there is no evidence to suggest this in the history she provided or in the records. In the absence of a personality disorder, her profile suggested an Anxiety or Mood Disorder, which I do find to be the case at this time.

Discussion of Credibility of the Applicant:

The applicant was generally credible. Her report of her history and the history of her injuries was consistent with the records. She reported many non-industrial factors that were not indicated in the records including her daughter's eye injury as well as her son's difficulties transitioning to the first grade. She also reported a diminishment of symptoms since being prescribed medication as well as denying certain symptoms including hallucinations. Generally patients looking to maximize the value of their claim will not volunteer non-industrial stressors, will tend to pan-endorse psychiatric symptoms, and will not report any improvement in symptoms.

Discussion of Diagnoses:

Based on the history that the applicant presented, psychological testing and my mental status examination, I find that she meets DSM-IV criteria for Major Depressive Disorder, Recurrent, Moderate. She has experienced more than one major depressive episode, in which she experienced symptoms for more than two weeks for most of the day. These symptoms include depressed mood, sleep difficulty, low energy, increased appetite and significant weight gain, difficulties with focus and concentration, low energy and passive suicidal ideation. These symptoms do not indicate a mixed episode, are a cause of great distress, are not caused by substance abuse, and are not due to normal grief or bereavement. Another disorder does not better explain the major depressive episode, and she does not appear to have ever had a manic, mixed, or a hypomanic episode. Due to the number of symptoms, and their degree of severity, the applicant's depressive disorder is considered moderate.

She also meets criteria for Generalized Anxiety Disorder because she experiences excessive anxiety and worry that she is unable to control. She is also experiencing sleep disturbances, low energy, irritability, and difficulties with focus and concentration.

Discussion of GAF Rating:

I have diagnosed the applicant with a current GAF score of 56 based on her moderate psychiatric symptoms. These include daily depressed mood, sleep difficulty, persistent anxiety, irritability, isolating, difficulty with focus, and passive suicidal ideation without intent. A higher GAF score in the 61-70 range indicates mild symptoms, however the applicant's symptoms are more moderate rather than mild at this time. A lower GAF in the 41-50 range is not appropriate because while the applicant is experiencing moderate symptoms, she has not lost touch with reality, and is generally functioning in her daily life.

Discussion of Causation:

According to the applicant and as is corroborated by the records that I received, the applicant was psychiatrically asymptomatic and doing well emotionally immediately prior to her [redacted] injury. It is clear that it was the severe burns to her hands and the sequelae of her injury that caused her psychiatric injury. Her marriage was stable, her [redacted] transition problems were minor and she was unconcerned about her [redacted] eye injury as she was stable and insured through the applicant's work. It does not appear that there were any significant non-industrial factors that contributed to the cause of her psychiatric injury. I opine that the applicant's Depressive Disorder, Recurrent, Moderate and Generalized Anxiety Disorder was caused 100% by the industrial injury to her hands.

Discussion of Compensability of Psychiatric Injury:

With regard to injuries sustained on or after [redacted] Senate Bill 863 changed the law governing compensable consequence psychiatric injuries. SB 863 modified Labor Code 4660.1(c) as follows,

"(c)(1)Except as provided in paragraph (2), there shall be no increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, arising out of a compensable physical injury. Nothing in this section shall limit the ability of an injured employee to obtain treatment for sleep dysfunction, sexual dysfunction, or psychiatric disorder, if any, that are a consequence of an industrial injury.
(2) An increased impairment rating for psychiatric disorder shall not be subject to paragraph (1) if the compensable psychiatric injury resulted from either of the following:
(A) Being a victim of a violent act or direct exposure to a significant violent act with the meaning of Section 3208.3.
(B) A catastrophic injury, including, but not limited to, loss of a limb, paralysis, severe burn, or severe head injury. "

In [redacted], the California Society of Industrial Medicine and Surgery (CSIMS) Psychiatric and Psychological Task Force released a paper entitled "A Systematic Definition of 'Catastrophic' from a Clinical Perspective." Given that Labor Code 4660.1(c)(2)(B) does not offer a clear definition of the term "catastrophic," the paper proposes a clinically based scoring system to classify injuries as "catastrophic" or "non-catastrophic." The paper identifies twelve (12) factors that can medically contribute to a catastrophic injury. The approach incorporates five (5) factors drawn directly from the language of the Labor Code and seven (7) factors relating to the effects of an injury. The following chart describes these 12 factors. The authors suggest a cutoff score of 4. Factors 1 through 4 are statutory therefore they automatically score a 4. The authors propose factor 5 to cover all other injuries of equal medical significance. Factors 6 through 12 are valued as 1 each.

Factors defining a catastrophic injury:

1. Loss of a limb (4 points)
2. Paralysis (4 points)
3. Severe Burn (4 points)
4. Severe head injury (4 points)
5. A physical injury determined by substantial medical evidence to be of equal medical significance to those specified in Labor Code 4660.1(c)(2)(b)
6. A period of temporary total disability of at least two years and/or inability to return to the injured worker's regular job as determined by a panel QME or AME (1 point)
7. Treatment for an industrial injury resulting in one or more of the following (1 point)
    a. Three or more surgeries
    b. Three or more hospitalizations
    c. Permanent need for ambulatory assistive device (as determined by a panel QME or AME)
8. Industrial injury with or without comorbid, naturally occurring conditions resulting in award of Social Security Disability Benefits (1 point)
9. Major post-injury change in psychosocial circumstances determined by a mental health panel QME or AME to be related in whole or in part to the injury including at least one of the following: 1) Bankruptcy, 2) Loss of home, 3) Legal separation and/or divorce. (1 point)
10. Cognitive deficit requiring 15 or more sessions of neurocognitive therapy and/or permanent cognitive loss resulting in a whole person impairment

(WPI) of 7% or greater pursuant to Table 13-6 as determined by a mental health panel QME or AME. (1 point)

11. Chronic pain from an industrial injury resulting in use of a spinal cord stimulator, implantable pain pump, and/or chronic narcotic maintenance therapy. (1 point)
12. Serious mental illness including Major Depressive Disorder, Post-Traumatic Stress Disorder, or the equivalent diagnosed by a panel QME or AME, and lasting one year or longer. (1 point)

Based on the above table, the applicant meets factor 3, severe burn. This is equal to the cut-off of 4, therefore the applicant's injury meets the clinical definition of "catastrophic" proposed by CSIMS.

Permanent and Stationary Status:

I do not anticipate that she will be psychiatrically permanent and stationary until her hand condition is first permanent and stationary. Thus she has not yet reached maximal medical improvement psychiatrically and therefore is not yet permanent and stationary.

Future Treatment:

I recommend biweekly visits with a psychiatrist for psychiatric medication management until she is stabilized on an appropriate medication regimen at which time psychiatric visits can be monthly. She should also attend weekly psychotherapy sessions with a supportive psychotherapist. She should receive this treatment for at least the next 4 months or until she is permanent and stationary for her hand condition, whichever occurs later.

Periods of Disability:

The applicant does not appear to have been temporarily disabled on a strictly psychiatric basis at any time.

Apportionment:

At this point the applicant is not yet permanent and stationary and therefore a discussion of apportionment is premature.

I do note that Ms. [redacted] has had previous depressive episodes, past marital problems including an episode of domestic violence, her daughter has ongoing

medical requirements related to her past eye injury and is currently uninsured as the applicant is not working full time, and her son is having minor transitional issues to the first grade in addition to being in speech therapy. These may constitute apportionable issues and will be considered when the applicant is psychiatrically permanent and stationary.

Other Recommended Evaluations

I would like to see her back after at least 4 months of mental health treatment or when she is permanent and stationary for her hand condition, whichever occurs later.

OPINION ON INDUSTRIAL CAUSATION

Within reasonable medical probability, the actual events of employment were predominant (>50%) to all the causes combined to have produced a psychiatric injury. This injury meets requirements under section 3208.3 for predominant cause. **The applicant's Depressive Disorder, Recurrent, Moderate and Generalized Anxiety Disorder was caused 100% by the industrial injury to her hands.**

This does appear to be a catastrophic injury as defined by Labor Code 4660.1 as the applicant appears to have suffered a severe burn to her hands at work. Her psychiatric injury does appear to be industrial.

In this case it does not appear that section 3208.3(b)(2) applies as this case is not a direct result of exposure to significant violent acts. Section 3208.3(h) does not apply as personnel actions were not a substantial cause of the psychiatric injury.

The injuries have arisen out of employment and during the course of employment.

I defer the determination of causation regarding her hand injuries to the appropriate medical specialists.

TEMPORARY DISABILITY

The applicant does not appear to have been temporarily disabled on a strictly psychiatric basis at any time.

PERMANENT AND STATIONARY

She has not yet reached maximal medical improvement and therefore is not yet permanent and stationary.

FACTORS OF DISABILITY

Factors of permanent disability are deferred as the applicant is not yet permanent and stationary.

PERMANENT DISABILITY

Permanent disability is deferred as the applicant is not yet permanent and stationary.

NEED FOR FUTURE MEDICAL/ PSYCHIATRIC TREATMENT

Medical treatment was reasonable and necessary to cure and relieve the effects of the injury in accordance with Labor Code Section 4604.5. The ACOEM Guidelines appeared to have been utilized by treating physicians and shall be presumed to be correct as to the issue, extent and scope of medical treatment involved. She has not yet reached maximum medical improvement and additional treatment is necessary to achieve maximum medical improvement as described above.

I recommend biweekly visits with a psychiatrist for psychiatric medication management until she is stabilized on an appropriate medication regimen at which time psychiatric visits can be monthly. She should also attend weekly psychotherapy sessions with a supportive psychotherapist. She should receive this treatment for at least the next 4 months or until she is permanent and stationary for her hand condition, whichever occurs later.

I would like to see her back after at least 4 months of mental health treatment or when she is permanent and stationary for her hand condition, whichever occurs later.

VOCATIONAL REHABILITATION

Vocational rehabilitation will be addressed upon reevaluation as the applicant is not permanent and stationary.

I defer to the appropriate specialist in terms of to what extent her hand injuries may require vocational rehabilitation or a modified position.

APPORTIONMENT ACCORDING TO SB 899 LC 4663

At this point the applicant is not yet permanent and stationary and therefore a discussion of apportionment is premature.

I do note that Ms. [redacted] has had previous depressive episodes, past marital problems including an episode of domestic violence, her daughter has ongoing medical requirements related to her past eye injury and is currently uninsured as the applicant is not working full time, and her son is having minor transitional issues to the first grade in addition to being in speech therapy. These may constitute apportionable issues and will be considered when the applicant is psychiatrically permanent and stationary.

CONCLUSIONS

1) The patient is diagnosed with the following DSM-IV-TR disorders:
   Major Depressive Disorder, Recurrent, Moderate
   Generalized Anxiety Disorder
2) These disorders have arisen out of the course of employment. Employment at [redacted] School District is predominant as to all other causes combined to have produced the psychiatric injuries. The applicant's Depressive Disorder, Recurrent, Moderate and Generalized Anxiety Disorder was caused 100% by the industrial injury to her hands.
3) The applicant is assigned a GAF of 56 corresponding to a WPI of 21.
4) The applicant does not appear to have been temporarily disabled on a strictly psychiatric basis at any time.
5) She has not yet reached maximal medical improvement and therefore is not yet permanent and stationary.
6) She requires further treatment in order to achieve maximal medical improvement. I recommend biweekly visits with a psychiatrist until she is stabilized on an appropriate medication regimen at which time psychiatric visits can be monthly. She should also attend weekly psychotherapy. I recommend this treatment for at least the next 4 months or until she is permanent and stationary for her hand condition, whichever occurs later.
7) Issues of permanent disability, factors of disability, apportionment, and vocational rehabilitation are deferred until the applicant has reached permanent and stationary status on a psychiatric basis.
8) I would like to see her back after at least 4 months of mental health treatment or when she is permanent and stationary for her hand condition, whichever occurs later.

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this evaluator, including the applicant's direct anamnesis.

Thank you for the opportunity of serving as agreed medical evaluator, in the specialty of Psychiatry, for this most interesting case and condition.

Sincerely,

[redacted]

Gabor Vari, M.D., QME
Clinical Instructor of Psychiatry
UCLA School of Medicine
Diplomate, American Board of
Psychiatry and Neurology
Diplomate, American Board of
Addiction Medicine

Attachments: Appendix A Work Function Impairment Form, Appendix B Declaration

APPENDIX A - WORK FUNCTION IMPAIRMENT FORM

	WORK FUNCTION	IMPAIRMENT	DATA
1.	**Ability to comprehend and follow instructions.** (A) Maintain attention and concentration for necessary periods; (B) Understand written and oral instructions; (C) Perform work requiring setting limits, tolerance and standards.	**Deferred**	History and Psychiatric Examination
2.	**Ability to perform simple and repetitive tasks.** (A) Ask simple questions or request assistance; (B) Perform activities of a routine nature; (C) Ability to remember locations and work procedures.	**Deferred**	History and Psychiatric Examination
3.	**Ability to maintain a work pace appropriate to a given workload.** (A) Perform activities within a schedule, maintain regular attendance and be punctual; (B) Complete normal work day and work at a constant pace.	**Deferred**	History and Psychiatric Examination
4.	**Ability to perform complex or varied tasks.** (A) Synthesize, coordinate and analyze data; (B) Perform tasks requiring precise attention of set limits, tolerance and standards.	**Deferred**	History and Psychiatric Examination
5.	**Ability to relate to other people beyond giving and receiving instructions.** (A) Get along with co-workers or peers; (B) Perform work activities requiring negotiating, explaining or persuading; (C) Respond appropriately to criticism.	**Deferred**	History and Psychiatric Examination
6.	**Ability to influence people.** (A) Ability to convince or direct others; (B) Understanding the meaning of words and use them effectively; (C) Interact appropriately with people.	**Deferred**	History and Psychiatric Examination
7.	**Ability to make generalizations, evaluations or decisions without immediate supervision.** (A) Recognize the potential hazards and follow precautions; (B) Understand and remember detailed instructions; (C) Make independent decisions or judgments; (D) Set realistic goals and make plans independent of others.	**Deferred**	History and Psychiatric Examination
8.	**Ability to accept and carry out responsibility for direction, control and planning.** (A) Set realistic goals or make plans independent of others; (B) Negotiate, instruct and supervise; (C) Respond appropriately to changes in work conditions.	**Deferred**	History and Psychiatric Examination

MINIMAL	=	causing discomfort, but not disabling
VERY SLIGHT	=	detectable impairment
SLIGHT	=	noticeable impairment
MODERATE	=	marked impairment
SEVERE	=	unable to perform work functions

APPENDIX B - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

[redacted]

[redacted]

[redacted]

[redacted]

_____

Gabor Vari, M.D.
Diplomate, American Board of
Psychiatry and Neurology

Gabor Vari, M.D.

DIPLOMATE AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY
QUALIFIED MEDICAL EVALUATOR

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PANEL QUALIFIED MEDICAL EVALUATION IN THE SPECIALTY OF PSYCHIATRY WITH PSYCHIATRIC TESTING

[redacted]

Re: [redacted]
Employer:
WCAB No.:
Applicant DOB:
Dates of Injury:
Claim/File No.:
Date of Evaluation:
Place of Evaluation:

Dear Parties:

Pursuant to your authorization, [redacted] underwent a Panel Qualified Medical Evaluation, in the specialty of Psychiatry, on [redacted] at my Los Angeles, California office. The undersigned acted in the capacity of Panel Qualified Medical Evaluator, in the specialty of Psychiatry.

Dr. Vari conducted the interview, reviewed all records, performed a mental status examination, and formulated the diagnosis, conclusions, and discussion, including the opinion on causation, temporary disability, permanent disability, degree of disability, future care, work restrictions, and apportionment. Testing was administered by Dr. Vari and interpreted by Dr. Vari except for the MMPI which was interpreted by Pearson Assessments. The report was authored and edited by Dr. Vari. All opinions expressed herein are solely the opinions of Dr. Vari.

Prior to the evaluation, the entire medical file made available to the undersigned was fully reviewed. All of the records reviewed were instrumental in this evaluator arriving at the opinions as expressed in this report.

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality) and that any information provided, as well as the results of the psychological testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. Prior to the evaluation, the applicant was advised of the right to ask questions and the right to end the evaluation based on good cause pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

If the applicant wishes to review this report, he or she should only review it under the supervision of a therapist or psychiatrist because the report may be easily misinterpreted by the applicant. This psychiatric report is confidential and privileged. Some individuals and family members may misunderstand and/or distort the information in this report. This may result in significant psychological harm to the applicant or may interfere with treatment and recovery from illness.

For individuals with self-destructive or violent tendencies, the consequences of disclosure of this report may be serious. This report is meant for the use of qualified professionals only and those with the need to know by law. Persons breaching the confidential nature of this report are acting against medical advice and assume any and all risks and liabilities of doing so.

Billed Under ML-104, time spent includes:

1. A psychiatric evaluation which is the primary focus of the medical-legal evaluation.
2. Face-to-face interview with the applicant. **2.00 hours**
3. Review of medical records including prior report(s) **6.50 hours**
4. Preparation, writing and editing of this report. **4.25 hours**
5. Psychological Testing **2.25 hours**

Additional time was spent in administering psychiatric diagnostic testing which will be billed separately under Code 96101, to be paid according to the current fee schedule.

There are extraordinary circumstances related to the medical condition being evaluated. These extraordinary circumstances justify the use of this procedure code, and are as follows:

1. This psychiatric evaluation requires an extraordinary complex, detailed developmental, family, social, and psychiatric history. This level of information is necessary in order to adequately and credibly address essential issues.

2. Psychiatric protocols are required in order to address the issue of permanent work function capacity. These include the evaluation, assessment and analysis of multiple, complex work functions.

3. This psychiatric evaluation necessitates assessment for the presence or absence of exaggeration due to psychiatric disorder or malingering. This process requires complex analysis in order to determine essential issues such as compensability of the claimed injury.

4. In some cases, there are extensive medical records, which are of a highly complex nature, and sometimes contain conflicting information. The review and analysis of these records often requires increased time.

5. Ancillary documentation is sometimes provided, such as personnel records, deposition transcript, job analysis, or other non-medical records, which must be reviewed and analyzed in order to address relevant issues resulting in increased time of records and preparation of report.

IDENTIFYING DATA

[redacted] is a [redacted]-year-old [redacted] man who lives in [redacted] in a townhouse that he rents. He lives with his [redacted] and their [redacted]. He drove himself to the evaluation.

He is claiming injury to his upper extremities, head, knee, neck and back, psyche, and sexual dysfunction stemming from an injury on [redacted] Additionally, he is claiming injury to his left shoulder, psyche, sleep function, and urological function stemming from an injury on [redacted]

REVIEW OF FILE

NON-MEDICAL RECORDS:

Cover Letter, signed by [redacted] dated [redacted]

The applicant was employed as a stocking supervisor. He alleged to have sustained an injury on [redacted] to his left shoulder, psyche, urology issues, as well as sleep disorder when he was lifting pallets. While the injury had been admitted, the nature and extent of his injuries were in dispute. He was currently treating with Dr. [redacted] as he recently underwent carpal tunnel surgery in [redacted] Dr. [redacted] was utilized as the Panel Qualified Medical Examiner in orthopedics, who did find the applicant's left shoulder to be industrial. The applicant was also seen by Dr. [redacted] the Panel Qualified Medical Examiner in urology, who did not believe that the applicant's alleged sexual dysfunction was industrially related. Furthermore, the defendant had denied the applicant's alleged psychiatric complaints as he had never treated nor complained to the doctors regarding any psychiatric issues. In addition, the applicant also sustained a prior injury on [redacted] to the upper extremities, head, knee, neck and back when he was attempting to stock product, and he reached after something that caused him to fall and injured himself. The application was later amended to include psyche and sexual dysfunction allegation which were later denied. The

injury itself was admitted but the nature and extent were at issue. The defendant utilized Dr. [redacted] as the Panel Qualified Medical Examiner in orthopedics, who declared the applicant to have reached maximum medical improvement back in [redacted] and did find causation for the right thumb, right wrist, neck, back and left knee. The defendant disputed any psychiatric allegations as the applicant had never treated nor reported any psychiatric complaints.

The customary determinations on causation, diagnosis, temporary and permanent disability, permanent and stationary status, need for future medical treatment, apportionment, and work status were requested. This examiner was requested to comment on the reasonableness and necessity of all treatment rendered to the applicant.

Workers' Compensation Claim Form, dated [redacted]

[redacted] the applicant fell from a ladder and sustained injuries to his right thumb, right wrist, right arm, head, left knee, neck, and back.

Deposition of [redacted] dated [redacted]

The applicant was currently residing on [redacted] California. He had been living in this address for 5 years. He was born on [redacted] in [redacted] He was taking pain medication prescribed by Dr. [redacted] his current treating doctor. He had not served in the military.

He was currently employed as a supervisor by [redacted] and had been working modified duties for 7 months. His modified duties consisted of no lifting more than 15 pounds and taking breaks whenever he wants to. He worked with modified duties 30 to 35 hours per week. He was hired by [redacted] on [redacted] At the time of his injury on [redacted] his job title was overnight supervisor. He worked in this position for 5 ½ years. As an overnight supervisor, he oversaw 17 employees. He would direct and do the actual labor. 50% of his time was spent on directing and 5% on doing the actual labor. He would work from 10 pm to 5:30 am. With the actual labor, they would carry boxes or products such as blenders, microwaves, tableware, plates and glasses, and put them on the upper shelves and lower shelves. These items weighed from 5 pounds to 60 pounds. During the year before his injury in [redacted] the average number of hours he worked per week was 40 hours. At the time of his injury, he was paid $[redacted] per hour. His current senior manager was [redacted] Before working for [redacted] he worked as a [redacted]

supervisor at [redacted] for [redacted] years. His job was to secure the entrance of the patrons to the sports arena, make sure that they were not bringing any illegal items inside, and make sure that everybody was in their right seats. He did not sustain any injuries while working at [redacted] He left because another company took over the security. He was actually an employee of [redacted] working at the [redacted] location. When another company took over security at the [redacted] he was still an employee of [redacted]. He decided to leave Inter-con because the pay was not enough. Before working for [redacted], he worked at [redacted] for [redacted] years. His job was overnight stocking. He did not sustain any injuries while working for Target. He left [redacted] because the pay was not enough. Before working at [redacted] he worked as a security supervisor at [redacted] for [redacted] years. He was working for a private security company named [redacted] He did not sustain any injuries while working for [redacted] He left because the pay was not enough. Before [redacted], he worked as a factory worker for [redacted] for [redacted] years. This was a shoe factory. He did not sustain any injuries while working for [redacted] He left because the company moved overseas.

He went to [redacted] College. He did not receive any state disability benefits, unemployment insurance benefits, or long-term disability since his injury in [redacted] He did have an automobile accident 6 to 7 years ago, when he rear-ended another car. He was not injured in that accident. A claim was filed against him for the physical damage to the other car and against [redacted] his insurance, for personal injury.

Before his date of hire at [redacted] he did not have any problems with his back, neck, right thumb, right wrist, right hand, head, and left knee. His injury on [redacted] involved a fall from a ladder. The incident occurred while he was on his way down the 8-foot ladder. At that time, he was up on the ladder putting some boxes with tableware away. The box weighed 40 pounds. While he was coming down the ladder, he grabbed the earthquake bar that was attached to the shelves with his left hand, and it came loose and he fell backwards and lost his balance. His right arm, hand, wrist, thumb, and head hit the shelves all the way down. He landed on the ground on his back and left knee. The side of his left knee hit the ground. He was working with someone when the incident occurred. Two persons were helping him put the item on the shelf. His coworkers had stepped out of the stockroom when the incident happened. The two individuals who were with the applicant were [redacted] They worked under the applicant.

When the applicant fell, he got up after 3 to 5 minutes. He was still alone in the stockroom after 3 to 5 minutes. When he got up, he reported the injury to his manager, [redacted] Mr. [redacted] asked the applicant if he was okay. The applicant told Mr. [redacted] that he was still shaken up but he would be okay. He did not go to the clinic after that. He had treatment about 2 weeks later. He saw Dr. [redacted] at the [redacted] Emergency Room because he was experiencing dizziness.

After the applicant reported the injury to his manager, he sat down and he waited until his time was up so he could go home. He returned to work the next time he was scheduled to work. He worked on self-imposed modified duty and his manager was aware of this. Four days after the accident, he went to the emergency room and saw Dr. [redacted] A CAT scan was done. He was diagnosed with a concussion. Dr. [redacted] placed the applicant on moderate work.

Dr. [redacted] referred him to a neurologist at [redacted] and he had x-rays. The neurologist placed him on modified work with a restriction of no lifting because he had a bandage on his right wrist. The neurologist placed the bandage on his right wrist.

The applicant's attorney referred him to Dr. [redacted]

He also reported his injury to the store manager, [redacted] and senior manager, [redacted] the day after his accident. He also reported his injury to the overnight manager, [redacted] 2 or 3 days after reporting it to Mr. [redacted]

After the incident in [redacted] he worked modified duties. He missed a week from work before he started the modified duties. He was still on modified duties at this time.

At this time, he had pain, tightness and numbness in his lower back. The pain was like spasms. He experienced lower back pain every day, which lasted 3 to 5 hours. He had numbness throughout the day on a regular basis. There were periods that he did not have numbness. He had numbness 3 to 5 hours during the day. He felt tightness the whole day. He did not have low back pain, tightness, and numbness prior to the incident in [redacted] In the last 6 months, his back symptoms were still the same.

He also had problems with his right thumb. He experienced numbness, tightness, tingling, and sharp pain in his right thumb. He was experiencing sharp right thumb

pain half of the day every day. He had tingling the whole day. He did not have tingling about 3 to 4 hours of the day. He had tightness all day every day. He experienced the numbness half of the day every day. He did not have right thumb symptoms prior to the incident in [redacted] In the last 6 months, his right thumb symptoms were worse.

The applicant had sharp pain, cracking, numbness, and throbbing in his right wrist. He had sharp pain about 3 hours of the day every day. He experienced cracking about 2 or 3 times a week, which lasted 3 to 5 hours. He experienced numbness daily often throughout the day. The numbness lasted for about 30 minutes. He had throbbing in his right wrist 3 times a week, which lasted 2 to 3 hours. He did not have problems with the right wrist prior to the [redacted] incident. In the last 6 months, his right wrist symptoms were worse.

He complained of cracking and pain in his left knee. He described his left knee pain as if he had been running for a long time. He had an aching and dull pain. He had left knee pain about twice a week, which lasted 20 minutes. He had cracking twice a week, which lasted 3 to 5 hours. Prior to the [redacted] incident, he had no left knee problems. In the last 6 months, his left knee symptoms were the same.

He had driven to the deposition today. He would drive to a grocery store or go shopping twice a week. He needed help loading shopping carts. He had [redacted] He was not doing any activities with his children. He was not exercising.

Amended Application for Adjudication of Claim, dated [redacted]

The applicant claimed to have suffered a specific injury on [redacted] while employed as a stocking supervisor by [redacted] The application was amended to include injuries to psyche as well as sexual dysfunction.

Workers' Compensation Claim Form, dated [redacted]

On [redacted] the applicant sustained an injury to his left shoulder, psyche, as well as sleep disorder while lifting pallets.

Application for Adjudication of Claim, dated [redacted]

The applicant claimed to have suffered a specific injury to his shoulder, psyche, as well as sleep disorder on [redacted] while lifting pallets. He was employed as a supervisor by [redacted]

Answer to Application for Adjudication of Claim, dated [redacted]

The applicant was employed as a stocking supervisor. The injury was admitted, but the nature and extent of his injuries were in issue. The liability for self-procured treatment and for future medical treatment was reasonable and necessary.

MEDICAL RECORDS:

Discharge Instructions, [redacted] Medical Center and Orthopedic Hospital, dated [redacted]

Diagnoses: 1) Post concussive syndrome. 2) Thumb sprain with snuff box tenderness to palpation, status post splinting.

The applicant was advised to continue taking all his previous prescribed medications. He was to take all new medications as directed. He was to take regular Tylenol or Motrin as needed. He was precluded from strenuous activity for 1 week. He was to follow up in 2 to 3 days with his doctor for reevaluation. He might need a repeat x-rays of his thumb/wrist to evaluate for fracture. He was instructed to return to the emergency department for any worsening symptoms or any health concerns.

Work Status Report, signed by [redacted] M.D., dated [redacted]

The applicant might return to work on [redacted] He was precluded from extreme lifting of items weighing up to 10 pounds or climbing for 2 weeks.

Initial Comprehensive Medical Evaluation (Incomplete Copy), signed by [redacted] M.D., dated [redacted]

The applicant sustained a specific injury to his head, neck, right wrist, right thumb, low back, and left knee during the course of his employment for [redacted] and [redacted] as a supervisor.

Mechanism of Injury as Described by the Applicant: On [redacted] he was stocking merchandise while standing on an eight foot ladder. As he started to

step down, he grabbed onto the earthquake safety bar that should have been bolted down. The bar came out and he lost his balance causing him to fall off the ladder. As he was falling down, his body hit some shelves. He landed on his back. He was on the floor for about 2 to 3 minutes. The wind was knocked out of him.

He informed his manager, Mr [redacted], about the injury who just asked if he was okay. He continued to work.

On [redacted] he decided to go to the emergency room at [redacted] because he started feeling dizzy, nausea, and was very fatigued. X-rays and CT scan were obtained. A splint for his right thumb was provided. He was released on the same day and was sent back to work with restrictions.

He went again to [redacted] in [redacted] on [redacted] and saw an orthopedic specialist. X-rays were taken and he was told to exercise his hand. He was sent back to work with restrictions.

Job Description as Reported by the Applicant: Mr. [redacted] began employment for [redacted] and [redacted] as a supervisor in [redacted] He worked 8 hours per day, 5 days per week. His work duties entailed stocking and supervising.

Standing, walking, bending the neck and back, lifting up to 90 pounds, carrying, squatting, climbing, kneeling, twisting the neck and back, repetitive use of hands, simple grasping, strong gripping, fingering, and reaching at all levels were required.

Present Complaints: The applicant complained of constant, recurrent headaches associated with nausea, dizziness, memory problems, problems focusing, and trouble sleeping. The pain was described as pressure. He had been having trouble with his vision. He rated his pain 7/10. He also had frequent neck pain that radiated into his right upper extremity.

He complained of constant right wrist pain as well as numbness, tingling sensation, weakness, and loss of grip. He rated his right wrist pain 8/10. He also complained of constant right hand/thumb pain as well as numbness, tingling sensation, weakness, and loss of grip. He rated his right hand/thumb pain 8/10.

He had frequent pain in his low back. The pain was accompanied with numbness, weakness, tingling and burning sensation. He rated his low back pain 5/10. He also had intermittent pain in his left knee. He rated his left knee pain 3/10.

He complained of anxiety, depression, insomnia, and nervousness.

Work Status: Currently, he was working with restrictions.

Past Medical History: He denied a history of serious illness.

Past Work-Related Injuries: He denied any past work-related injuries.

Past Non-Industrial Injuries: He denied any previous automobile, sport, or personal injuries.

Past Treatment to Injured Body Parts: He denied any pre-existing disability to the injured body parts.

Past Surgeries: When he was 8 years old, he underwent right eye surgery to remove extra skin.

Current Medications: He was currently taking Ibuprofen.

Marital Status: He was married with 3 children.

Alcohol/Tobacco Use: He denied use of tobacco and consumption of alcoholic beverages.

Neurological Evaluation, signed by [redacted] M.D., dated [redacted]

The applicant presented for a neurological evaluation regarding his headaches.

Diagnostic Impression: 1) Status post closed head injury with posttraumatic head syndrome. 2) Depressive mood, situational. 3) Cervical and lumbosacral strain. 4) Status post contusion of the left knee with residual pain. 5) Rule out right carpal tunnel syndrome.

Recommendations: Medical records from [redacted] hospital were requested for review. Fioricet and Meclizine 25 mg were prescribed to be taken on an as-needed

basis. EEG as well as NCV/EMG of the right upper extremity were ordered. Continued present care was noted. Mr. [redacted] was to return in 6 weeks.

Doctor's First Report of Occupational Injury or Illness, by [redacted] M.D., dated [redacted]

Chief Complaint: The applicant's left shoulder was still sore. It popped when he moved it around.

History of Present Injury: He developed pain in his left shoulder after moving a pallet. He was seen 8 days ago and was treated conservatively. He was actually improving, but only a little.

Diagnosis: Left biceps tendinitis/shoulder sprain.

Treatment Plan: Physical therapy 3 times per week for 2 weeks was recommended. He would be switch to Daypro 2 pills once a day along with Prilosec 1 pill once a day as the Naprosyn was bothering his stomach. He was to return for follow up in 1 week. He was precluded from lifting items weighing over 25 pounds as well as overhead reaching.

Initial Report, by [redacted] M.D., dated [redacted]

History of Present Illness: The applicant was seen with a complaint of left shoulder pain from lifting a heavy pallet weighing 70 pounds at work on [redacted].

Social History: He denied tobacco use or consumption of alcoholic beverages.

Medications Taken: He was taking Motrin.

Diagnosis: Left shoulder strain.

Treatment Plan: Naproxen 550 mg was prescribed. Physical therapy 3 times per week for 2 weeks was ordered. He was to resume work at limited duty with no pushing, pulling, or lifting of items weighing over 25 pounds and no overhead reaching.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

Chief Complaint: The applicant felt better but still sore over the anterior and lateral aspect of his left shoulder. He had not attended physical therapy yet.

History of Present Injury: He was lifting a heavy pallet at work and hurt his left shoulder. It popped last week and he had extensive tenderness over the biceps tendon.

Diagnoses: 1) left shoulder sprain, resolving. 2) Left biceps tendinitis, resolving. 3) Likely residual subacromial bursitis.

Treatment Plan: Anaprox 550 was refilled. Physical therapy 3 times per week for 2 more weeks was recommended. He was precluded from lifting items weighing over 25 pounds as well as overhead reaching. He was to return for follow up in 1 week.

Therapy Initial Evaluation, signed by [redacted] D.P.T., dated [redacted]

The applicant was referred for physical therapy regarding his left shoulder.

Mechanism of Injury: He was lifting a heavy pallet from the floor and felt a burning sensation over his left lateral shoulder. The next day, he had more pain. He was off on vacation for the week after and he rested it. It felt a lot better, but when he returned to work it started bothering him again.

Chief Complaint: He complained of constant bruise pain in his left lateral deltoid. He was doing a lot of climbing ladders and overhead lifting at work.

Assessment: Examination was consistent with the medical diagnosis of left biceps tendonitis.

Treatment: Treatments consisted of therapeutic exercises, chemical for iontophoresis, electrical stimulation, electrodes, shoulder-ranger master overhead pulley, and cold/heat compress.

Therapy Report, By [redacted] P.T., dated [redacted]

Subjective: The applicant complained of pain in his shoulder. He was doing his home exercise program.

Work Status: He was working on modified activity.

Assessment: Overall progress was slower than expected.

Treatment: Treatments included therapeutic exercises, chemical for iontophoresis, iontophoresis, and electrical stimulation.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

History of Present Illness: The applicant returned for a follow-up of a sprain of his left shoulder. He felt the pattern of symptoms was still sore. He still had significant pain. He had been taking Anaprox DS 550 and it was helping. He had attended physical therapy and it was helping.

Assessment: Shoulder sprain.

Plan: Methylprednisolone Dos-Pak and Prilosec 10 mg were dispensed.

Physical Therapy: He was to continue physical therapy as scheduled.

Activity: He was precluded from lifting, pushing, or pulling over 25 pounds.

Therapy Report, signed by [redacted] dated [redacted]

Subjective: The applicant was avoiding repetitive use of his left arm due to shoulder pain. His pain was constant.

Work Status: He was working modified activity.

Assessment: Overall progress was as expected.

Treatment: Treatments consisted of therapeutic exercises, chemical for iontophoresis, and electrical stimulation.

Therapy Report, signed by [redacted] dated [redacted]

Subjective: The applicant's shoulder was better. He now had more soreness in his left shoulder than pain.

Work Status: He was working at modified activity.

Assessment: Overall progress was as expected.

Treatment: Therapeutic exercises, electrical stimulation, and functional activities were performed.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

History of Present Illness: The applicant was seen for a follow-up of his left shoulder sprain. He had 80% improvement. He had been attending physical therapy.

Habits: He was a non-smoker and none to mild social drinking only.

Assessment: Left shoulder sprain.

Physical Therapy: He was instructed to continue his previous therapy as scheduled.

Activity: He was precluded from pushing, pulling, or lifting items weighing greater than 40 pounds.

Progress Note, By [redacted] M.D., dated [redacted]

Subjective: The applicant complained of mild pain in his shoulder. He had mild aching pain with some tightness. He was taking Ibuprofen which was helping.

Habits: He was a non-smoker and none to mild social drinking only.

Assessment: Left shoulder sprain.

Plan: He was to continue taking his medication.

Activity: He was precluded from pushing, pulling, or lifting items weighing greater than 40 pounds.

Panel Qualified Medical Examination in Orthopedics, signed by [redacted] M.D., dated [redacted]

History of Present Illness: The applicant was involved in an accident while working for [redacted] and [redacted] as a put-away merchandise supervisor on [redacted] His job duties involved lifting and carrying about as much as about 90 pounds, bending at the waist, stooping, working in awkward positions, balancing, pushing and pulling with the hands, standing and walking for the entire work shift, squatting, kneeling, repetitive use of the feet to use the forklift, use of the hands above shoulder and head level, repetitive use of hands, use of the hands to grip forcibly and lightly, use of the hands for fine dexterity, going up and down stairs, and climbing up and down ladders.

On [redacted] he was standing on an eight foot ladder on the top rung when he grabbed the earthquake reinforcement bar with his left hand. The earthquake reinforcement bar was holding shelves and gave way causing him to fall off the ladder first striking the shelves with the back of his head and right trapezial area and right thumb. He fell then struck the concrete pavement striking unknown body parts. He did not lose consciousness but was immediately dazed. After the accident, he noticed pain in his right thumb, right wrist, head, neck, low back, and right side of his abdomen.

The next day, he noticed the onset of left knee pain.

He developed numbness and tingling in the upper and lower extremities immediately following the accident.

He informed his supervisor Anthony Casanova immediately after the accident.

He had continue to work following the accident but self-limited his physical activities finishing the work shift. He was off work for about 2 days. In addition, he took 4 days of vacation because of his complaints in [redacted]

He then returned to work working with restrictions and continued to work with restrictions to the present time.

He was seen at [redacted] Hospital emergency room four days after the accident on [redacted] He was examined and an MRI of an unknown body part was obtained. He was subsequently seen by another doctor. He was examined and x-rays of the right thumb, neck and left knee were obtained.

He was also treated with a muscle stimulating unit which he last used about one month ago. He underwent MRIs of the right thumb, neck, mid back, low back and left knee. He also underwent electromyography and nerve conduction velocity study of the upper extremities and neck and lower extremities and low back.

He was treated with Cyclobenzaprine, Hydrocodone, Medrox pain ointment, Ketoprofen, Naproxen and Omeprazole.

Past Medical History: He denied a history of illness. He was taking Advil and was using Medrox pain ointment. He took Aleve which he had been taking on his own.

Present Complaints: He complained of right thumb numbness and tingling which occurred off and on daily involving the entire thumb from the tip to the corresponding metacarpal and right thenar muscles.

He had had no pain in his right thumb for about the last 6 months.

He also complained of weakness in power grip in the right hand.

He had off and on headaches, 3 times per month. The headache pain complaints spontaneously occurred. The pain involved the posterior aspect of the head.

He also complained of constant lower back pain. He pointed to the mid low back area.

He also had numbness and tingling in the posterior aspect of his thighs, knees, and legs which occurred off and on weekly. He did complain of crackling noise in his left knee.

He filled out a form regarding activities of daily living. He had level 2 impairment with being able to stand, sit, recline, walk, go up and down stairs, grasp or grip, manipulate small items, ride in a car or bus, as well as driving a car or travel by plane. He had level 3 impairment with ability to type, lift, and sexual function. He had level 5 impairment with being able to have a restful night sleep pattern.

He was depressed.

Diagnoses: 1) Right thumb contusion and sprain. 2) Cervical sprain, resolved. 3) Thoracic sprain, resolved. 4) Lumbosacral contusion and sprain. 5) Abnormal lumbar MRI report dated [redacted] with loss of disc height noted at T12-L1, L1-L2, L5-S1 levels. L4-L5 with a 1 mm diffuse disc protrusion which produced effacement of the thecal sacroiliac joint, bilateral neural foraminal stenosis and encroachment of the nerve root, left more so than right. At L5-S1, 2mm diffuse disc protrusion that effaced the thecal sacroiliac joint, bilateral neural foraminal stenosis and encroachment of the exiting nerve root. Disc desiccation noted at L1-L2 and L5-S1 levels. Schmorl's node identified at multiple spinal levels, annular tear visualized at L5-S1 level posteriorly and straightening of the lumbar lordosis. Correlate clinically for muscle spasm. 6) Left knee contusion and sprain.

Medical Causation: The applicant's present condition relative to his right thumb, right wrist, neck, mid back, low back, and left knee was industrially related and secondary to the accident on [redacted]

Permanent and Stationary Status: His condition became permanent and stationary three months prior to this evaluation as his complaints have remained essentially the same for the past three months.

Factors of Permanent Disability: Subjective factors of disability included numbness and tingling in the right thumb and corresponding metacarpal and thenar muscles, headaches, low back pain, and left knee crackling noises with motion of the left knee sometimes.

Objective factors of disability consisted of decreased sensation of the entire right thumb and corresponding metacarpal and thenar muscles; decreased sensation posterior aspect of the left thigh, knee, and leg; atrophy of the left calf of 1 cm; loss of lumbar left lateral bending of 7 degrees; loss of lumbar right lateral bending of 14 degrees; loss of lumbar flexion of 25 degrees; loss of lumbar extension of 9 degrees; and grip strength loss in the right hand of 7%.

Based on the lumbar MRI report on [redacted], he had a permanent work restriction precluding very heavy lifting.

Maximum Medical Improvement Status: He had reached maximum medical improvement.

Future Medical Care: Provisions should be made for orthopedic follow up, pain medication and non-steroidal anti-inflammatory medication and short courses of

physical therapy for exacerbation of the applicant's pain complaints. There was no need for provision for surgery on an industrial basis.

Apportionment: Causation of the applicant's right thumb, low back, and left knee complaints 100% to the injuries sustained on [redacted] 0% to non-industrial factors; and 0% to other industrial injuries based on reasonable medical probability.

The opinion was based on the fact that he had no prior injuries or complaints to the involved body parts before the accident on [redacted] and no subsequent injuries to these body parts after the accident on November 2, 2010.

Vocational Rehabilitation: He was currently working for [redacted] and [redacted] as a supervisor and wished to continue working. He was not a qualified injured worker and vocational rehabilitation was not indicated.

Medical Report, by [redacted] M.D., dated [redacted]

Impairment Summary: The final WPI was 16%.

Lumbar spine range of motion method WPI was 9%.

Left upper extremity combined WPI was 1%. Left hand combined WPI was 1%.

Right upper extremity combined WPI was 7%. Right hand combined WPI was 0%.

Left lower extremity combined WPI was 0% and the right lower extremity combined WPI was 0%.

Lumbar Spine Impairment: WPI was 6%.

Lumbar range of motion impairments contribution to WPI was 3%.

Left wrist range of motion impairments contribution to WPI was 0%.

Right wrist range of motion impairments contribution to WPI was 0%.

Left knee range of motion impairments contribution to WPI was 0%.

Right knee range of motion impairments contribution to WPI was 0%.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

History of Present Illness: The applicant was seen for a follow-up visit. He complained of pain rated 8/10 at the end of his shift. He had difficulty climbing ladder that he had to do at work. He was taking Naprosyn.

Diagnoses: 1) Left shoulder sprain.

Plan: He was to continue taking his medication. He was referred for physical therapy 3 times per week for 2 weeks.

Activity: He was precluded from pushing, pulling, and lifting items weighing over 40 pounds and climbing ladder.

Therapy Report, by [redacted] P.T., dated [redacted]

Subjective: The applicant returned after hiatus. He was unable to attend due to personal/family reasons. He now felt able to continue physical therapy.

Work Status: He was working at modified activity.

Assessment: Overall progress was slower than expected.

Treatment: Treatments consisted of chemical for iontophoresis patch, electrodes, and electrical stimulation.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

History of Present Illness: The applicant presented for a follow-up for left shoulder sprain. He complained had been approved to continue physical therapy treatment. He felt about 40% better. He took Naprosyn.

Diagnoses: 1) Left shoulder sprain.

Plan: He was to continue taking his medication. He was to continue his previous therapy as scheduled.

Activity: He was precluded from pushing, pulling, and lifting items weighing over 40 pounds and climbing ladder.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

The applicant presented for follow up of his left shoulder sprain. His pain was still rated 4/10, but physical therapy was helping. He was a supervisor at [redacted]

Diagnosis: Left shoulder sprain.

Treatment Plan: Naprosyn was continued. He was instructed to continue his previous therapy as scheduled. 4 more sessions were authorized.

Work Status: He was still on modified work with restrictions of no lifting over 20 pounds and no climbing ladders.

Therapy Progress Note, by [redacted] dated [redacted]

The applicant had a session of physical therapy for his left shoulder. The treatment included therapeutic exercises, electrical stimulation, and iontophoresis.

Therapy Progress Note, by [redacted] dated [redacted]

The applicant had attended a physical therapy session for his left shoulder. He had some improvement but had continued left shoulder pain with overhead/strenuous activities. The treatment included therapeutic exercises, electrical stimulation, and therapeutic activity.

Therapy Progress Note, by [redacted] dated [redacted]

The applicant had physical therapy session for his left shoulder. He had approximately 70% improvement. The treatment included electrical stimulation, myofascial release/soft tissue mobilization, iontophoresis, therapeutic activity, and therapeutic exercise.

Progress Note, by [redacted] M.D., dated [redacted]

The applicant still had left shoulder pain, which was limiting his activity and movement. He had attended 5 sessions of physical therapy.

Assessment: Shoulder sprain.

Plan: He was referred for MRI of the left shoulder. He was still on modified work with restrictions of no lifting over 20 pounds and no climbing ladders.

Therapy Progress Note, by [redacted] dated [redacted]

The applicant had attended a session of physical therapy for his left shoulder. The treatment included electrical stimulation, iontophoresis, and therapeutic exercise.

Progress Note, by [redacted] M.D., dated [redacted]

The applicant was seen for follow up of his left shoulder sprain. He had run out of his medications. He was awaiting MRI. He felt that the pattern of symptoms was the same with a burning pain with driving or a sharp stabbing pain if he sleeps in a certain position. He had pain with lifting.

Assessment: Shoulder sprain.

Plan: He was dispensed Naproxen 550 mg. He was placed on modified duty with restrictions of no lifting over 20 pounds and no climbing ladders.

Progress Note, by [redacted] M.D., dated [redacted]

The applicant still had shoulder pain with certain positions. He was awaiting MRI. He felt that the pattern of symptoms was the same.

Assessment: 1) Shoulder sprain. 2) Impingement syndrome.

Plan: His medications were continued. He was still on modified duty with restrictions of no lifting over 20 pounds and no climbing ladders.

MRI of the Left Shoulder without Contrast, signed by [redacted] M.D., dated [redacted]

Impression: 1) Focal tear of the superior labrum with no tear of attachment of the tendon for long head of biceps. 2) Mild supraspinatus tendinosis. 3) Mild degenerative changes of the greater tuberosity.

Progress Note, by [redacted] M.D., dated [redacted]

The applicant had the MRI. His pattern of symptoms was still the same.

Assessment: Shoulder sprain.

Plan: He was referred to Dr. [redacted] of orthopedics on [redacted]

Initial Orthopedic Consultation, by [redacted] M.D., dated [redacted]

The applicant sustained an injury to his left shoulder while at work on [redacted] While he was lifting a 90-pound pallet and pushing hard, he felt a pop and strain in his left shoulder. He continued to have persistent left shoulder pain. He reported the injury. He was seen at [redacted] Center and was given a course of anti-inflammatory medications and physical therapy. His symptoms initially improved but his pain recurred. He was again sent back for physical therapy. He was able to return to modified work but he continued to have persistent left shoulder pain which did not resolve.

Current Complaints: He had slight to moderate left shoulder pain that occurred about the glenohumeral joint with occasional clicking and catching. He also had left shoulder pain about the subacromial region. His pain was exacerbated by heavy lifting, reaching, and pushing activities. Most of the pain occurred during the course of the day. He had occasional pain at night. He also had constant dull pain and intermittent sharp pain.

Clinical Impression: 1) Symptomatic traumatic impingement syndrome. 2) Distal clavicle arthrosis and superior labral tear in the left shoulder.

Treatment Recommendations: He was recommended to have an arthroscopic acromioplasty, distal clavicle resection, and labral repair. The applicant would like to have this surgery. Pending surgery, he was to continue a self-directed program. He was still on modified work.

Request for Surgery Authorization, by [redacted] M.D., dated [redacted]

Authorization was requested for outpatient surgery consisting of arthroscopic acromioplasty, resection of distal clavicle, labral repair, and possible rotator cuff repair in the left shoulder; 12 sessions of postoperative physical therapy; preoperative medical clearance; cold therapy purchase; CPM rental for 21 days; SurgiStim rental for 21 days; and assistant surgeon.

Primary Treating Physician's Initial Workers' Compensation Orthopedic Evaluation, signed by [redacted] M.D., dated [redacted]

History of Injury: On [redacted] during the course of his employment, he was coming down a ladder when he grabbed onto a shelf for support. The rack came lose, causing him to fall backwards. He landed about 8 feet to the ground below, landing on his stomach. Upon falling, he struck his head and other body parts against the shelves. He experienced immediate pain in his head, neck, right arm, lower back, and left knee. He reported the injury to his supervisor and completed his shift in pain. He took a couple of days off work and returned to work on full duty. After a couple of days, he was climbing a ladder when he began to feel dizzy. He left work early to seek medical care. He was examined in the emergency room at [redacted] An MRI study of his head was performed. His right hand was bandaged. He was given Ibuprofen 200 mg. He was discharged within a couple of hours. He took a week off and returned to full duty work. He continued working with ongoing pain in his neck, right arm/hand, lower back, and left knee.

In [redacted] during the course of his employment, he was lifting a pallet weighing about 80 to 90 pounds, at which time he had the onset of left shoulder pain. He reported the injury to his supervisor and was referred for medical care. He was soon after examined by a company physician at [redacted]. He was placed on light duty work. X-rays and MRI studies of the left shoulder were performed. He was given pain medication and anti-inflammatory agents. He was started on a course of physical therapy for his left shoulder twice a week for about 6 months, providing him temporary pain relief. Left shoulder surgery was recommended, which he did not go through with as he was changing his treating physician. He was also uncomfortable with the physician who was treating him through his workers' compensation carrier. He was last examined in [redacted]

After his injuries, he developed constant headaches, light headedness, episodes of short term memory loss, anxiety, and stress. He also developed sexual dysfunction due to his lower back pain. He had not received any treatment for these complaints. In [redacted] he was examined by a physician in [redacted] He was advised to continue working on light duty work. X-rays and MRI studies to his neck, right shoulder, right hand, lower back, and left knee were performed. He was given pain medication and anti-inflammatory agents. Electromyography studies of his upper and lower extremities were conducted. He was started on a course of physical therapy for his neck, right shoulder, right wrist/hand, lower back, and left knee 3 times a week for approximately a year, providing him temporary pain relief. He was under their medical care through early [redacted]

He was also examined by a neurologist once for his constant headaches. In [redacted] he was terminated while working on light duty. He was let go for unjust reasons. In early [redacted] he was examined by an orthopedic surgeon, Dr. [redacted] for a panel qualified medical examiner's evaluation. X-rays of his shoulders, arms, hands, spine, and left knee were taken. An electromyography study of his upper and lower extremities was done. He was examined once and did not recall the outcome of the report. He continued to receive workers' compensation disability benefits through June or [redacted] at which time the benefits were suspended. He had since continued taking over-the-counter Tylenol ES and Aleve for his pain.

Job Description: He began working as a supervisor at [redacted] in 2005. He worked 8 hours a day, 5 days a week. His duties at the time of injury entailed supervising, assisting customers, up-stocking, moving fixtures, re-arranging merchandise, and was in-charge of schedules. The precise activities required entailed prolonged standing and walking, as well as continuous fine maneuvering of his hands and fingers. There was also repetitive bending, stooping, squatting, twisting, turning, forceful pushing and pulling, forceful gripping and grasping, reaching to all levels, torqueing, lifting and carrying up to more than 90 pounds, as well as ascending and descending ladders.

Current Work Status: He was not working. He last worked in [redacted] He was receiving unemployment benefits.

Medications: He was taking Aspirin.

Social History: The applicant was married and had 3 children. He was not drinking or smoking.

Current Complaints: He complained of constant aching in the neck, at times becoming sharp and shooting pain. He experienced a pressure sensation in the neck area. His pain was travelling to his arms and hands. He had episodes of numbness and tingling in his arms and hands. He had frequent headaches, which he associated with his neck pain. He had stiffness in the neck. His pain increased with prolonged sitting and driving. He had difficulty sleeping and he would awaken with pain and discomfort. His pain level would vary throughout the day depending on activities. He complained of anxiety and stress due to his pain. Pain medication provided him temporary pain relief.

The applicant had continuous aching in the right shoulder, at times becoming sharp and throbbing pain. His pain would travel to his arm and hand. He had a clicking and grinding sensation in the right shoulder. He had episodes of numbness and tingling in his right shoulder/arm and hand. He complained of stiffness in the right shoulder. His pain increased with reaching, pushing, pulling, and lifting. His pain level would vary throughout the day depending on activities. He had difficulty sleeping and would awaken with pain and discomfort. Pain medication provided him temporary pain relief.

He had continuous aching in his right wrist and hand, at times becoming sharp, shooting, and burning pain. His pain would travel to his forearm. He had episodes of numbness and tingling in his right hand. He complained of weakness in his right hand. His pain increased with gripping, grasping, as well as repetitive hand and finger movements. He had difficulty sleeping and he would awaken with pain and discomfort. His pain level would vary throughout the day depending on activities. Pain medication provided him temporary pain relief.

He had continuous nagging pain in the lower back, at times becoming sharp and shooting pain. His pain would travel to his legs and feet. He had episodes of swelling, numbness, and tingling in his legs and feet. His pain increased with prolonged standing, walking, sitting, and driving, as well as bending, twisting, and turning. He had difficulty sleeping and he would awaken with pain and discomfort. His pain level would vary throughout the day depending on activities. He had difficulty maintaining an erection. He complained of anxiety and stress due to pain. Pain medication provided him temporary pain relief.

The applicant had continuous aching in the left knee, becoming sharp and shooting pain with standing and walking. He had occasional clicking and locking in his left knee. He had episodes of swelling in the knee. His left knee had given out, causing

him to lose his balance. He had difficulty standing and walking for a prolonged period of time. He had difficulty ascending and descending stairs. He was walking with an altered gait. His pain level would vary throughout the day depending on activities. He had difficulty sleeping and he would awaken with pain and discomfort. Pain medication provided him temporary pain relief.

Activities of Daily Living: Since the [redacted] injuries, there were episodes of increased pain, causing him difficulty with showering, dressing, and grooming. He was also more aware of proper body mechanics.

Diagnostic Studies: X-rays of the shoulder were within normal limits. X-rays of the cervical spine were within normal limits. MRI of the cervical spine noted a herniated nucleus pulposus at C2, C5, and C6. MRI of the shoulder was consistent with a possible torn labrum.

Diagnoses: 1) Herniated nucleus pulposus, cervical spine. 2) Cervical sprain and strain. 3) Torn labrum, left shoulder.

Causation: Absent evidence to the contrary and based on the available information, the applicant's injuries arose out of his employment.

Disability Status: He had persistent left shoulder pain. His condition had not yet reached the point of maximum medical improvement.

Treatment Plan: Home strengthening program was recommended. Should the applicant's symptoms not abate, MR arthrogram of the left shoulder and/or arthroscopic evaluation of the left shoulder on an industrial basis should be considered.

Work Status: He could return to his usual and customary job with a prophylactic work restriction of no work at or above shoulder level as well as no repetitive lifting at or above shoulder level.

Initial Orthopedic Joint Panel Qualified Medical Evaluation, signed by [redacted] M.D., dated [redacted]

Current Complaints: The applicant currently complained of an aching pain in the back of his neck. His pain was present all of the time. He was experiencing numbness and tingling, as well as radiating pain down both arms and into the fingers. The right side was hurting more than the left. Prolonged sitting or standing

and turning the head to the right aggravated his neck pain. He was currently using medication and ice to help alleviate the pain. On average, his pain was rated 7/10. He also complained of an aching pain in the whole right side of the back. His pain was present all of the time. He was experiencing numbness and a burning, tingling, radiating pain down both legs and into the toes. Walking more than 10 blocks, prolonged sitting, and bending aggravated the pain in the right side of his back. He was currently using medication, heat, and electrical stimulation to help alleviate the pain. On average, his back pain was rated 5/10. He also had a burning and cracking sensation in the left knee. His pain was present all of the time. He experienced numbness and burning with radiating pain down to the toes in the left foot. Prolonged walking and climbing stairs aggravated his left knee pain. His left knee felt as though it needed to crack all of the time. He was currently using heat, ice, electrical stimulation, and medication to help alleviate the pain. On average, his left knee pain was rated 8/10. He complained of right hand numbness and pain, which was present all of the time. He experienced numbness radiating up to the forearm, but not past the elbow. It was hard for him to close the right hand and he had cracking in the right wrist. Gripping, grabbing, using a computer, and writing aggravated his right hand pain. He was currently using medication and wearing a wrist brace but stopped because he felt it was hurting him more than helping. On average, his right hand pain was rated 5/10.

Activities of Daily Living: He was independent in most activities of daily living. Toileting, using the phone, walking, and shopping caused him pain. He was not doing housework and laundry. He could drive for about 30 minutes before he was in pain. He was forgetting more information since the accident. It was difficult for him to have sexual relations.

History of Injury: The applicant sustained 2 specific injuries while employed as a warehouse supervisor at [redacted] He suffered acute neck, low back, right hand, and left knee injury on [redacted] at work. He sustained additional specific injuries on [redacted] About 95% of his workday was spent on a ladder. He was atop an 8-foot ladder on [redacted] He began to climb down and as his leading foot touched the first rung, his foot slipped and he fell. He grabbed an earthquake pole in an effort to break his fall but it was not bolted down causing him to fall back. He hit the right side of his body on shelves, causing his body to twist as he fell. The applicant landed on an angle, on the back and left side of his body. No witnesses were around. He noticed most of the initial pain in his back and right hand. His right hand was very swollen. He was lying on the ground alone for about 10 minutes before he got up to report what had happened to his supervisor, [redacted] Mr. [redacted] filed a report that night, but he never

received a copy of it. He was told to sit down and then take the rest of day off'. He was asked if he needed to go to the hospital, but he did not want to go because nothing felt broken. He went home and tried to relax and lie down. He went back to work his next shift 12 hours later. He was just supervising, not lifting or climbing. The applicant's right hand was still very swollen. He stated that the lights and everything around him was moving and he felt as though he was going to faint. The applicant then went to the emergency room.

On [redacted] he went to the emergency room and was told that he had a concussion. He was sent to an orthopedic doctor, but he did not recall the name. X-rays of the left knee, right hand and the back were taken 2 days later. He was given over-the-counter pain medication and he did not remember if he was told any of the findings from the x-rays.

On or about [redacted] he felt sudden left shoulder pain as he lifted a box while working at [redacted] He told the supervisor and went to see the doctor his employer said to see that night. He was given pain medication and was examined. He never received any other treatment for this injury and stopped working for [redacted] on [redacted]

Two weeks after the accident, he got a lawyer and was sent to see Dr. [redacted] He received physical therapy to the back, left knee, neck, and right hand. It was about 15 to 18 sessions. It was beneficial. He was also prescribed medication. He then saw a neurologist, Dr. [redacted] He saw her 2 times and she performed a test. The applicant adds that he felt that she did not do what he thought she was supposed to.

Job Description: His job duties consisted of accepting deliveries, supervising 15 employees, showing employees where to stock items, stocking shelves, delegating breaks and lunches, resolving employee complaints or conflicts, driving a forklift to take out the trash and move pallets, noting product damage, and using a computer.

Occupational Injury: He was not currently working. He started working as a warehouse worker at [redacted] in [redacted] A few months after he was hired, he was promoted to a warehouse supervisor. He stopped working in [redacted] He was previously employed at the [redacted] as a security supervisor from [redacted] His duties were to supervise 40 employees, search for weapons and explosives, deal with complaints, and take tickets. He was on his feet and walking for whole 8-hour shift. Prior to that, he was employed as a cashier

supervisor at [redacted] from [redacted] His duties including moving large amount of cash, dealing with customer complaints, and providing customer service.

Past Medical History: He had eye surgery when he was 12 to remove extra cartilage. He was currently taking Advil.

Social History: He was not smoking and drinking alcohol. He was drinking 2 cups of coffee a week. He was married and had 3 children. He enjoyed traveling, watching television, going out to dinner, and trying different food and restaurants.

Assessment: 1) Status post mechanical fall off an 8-foot ladder, [redacted] 2) Chronic neck pain with multiple-level cervical degenerative disease without disk herniation. 3) Chronic thoracic sprain/strain with multiple level thoracic degenerative disk disease. 4) Chronic low back pain with 2 mm, L5-S1 degenerative disk disease on MRI. 5) Right wrist strain with electrodiagnostic evidence of carpal tunnel syndrome, right, mild, with clinical correlation with sensory deficits. 6) Left knee contusion with chronic left knee pain with a normal MRI of the left knee on [redacted] but with clinical evidence of a symptomatic synovial plica. 7) Asymptomatic plica, right knee, uninjured. 8) Left shoulder acute injury with same employer, [redacted] with MRI evidence of a focal superior labral tear, tendinosis, and type II acromion, with clinical evidence of impingement on MRI of [redacted]

Discussion: The applicant was declared permanent and stationary by Dr. [redacted] on [redacted] with an 8% WPI for the cervical and lumbar spine, 5% for the thoracic spine using the DRE method with 2% for chronic pain syndrome, and 1% for his right wrist sensory deficit.

Causation: Based on the available information, the specific work injury of [redacted] represented the main source of the applicant's spinal and right upper extremity problem. The specific injury of [redacted] produced his left shoulder injury and need for treatment.

Disability Status: His injuries had not yet achieved permanent and stationary or maximum medical improvement status. He was terminated from his employment on [redacted] due to the effects of his injuries. The injuries and his pain prevented him from doing the job properly or with any efficiency. Absent his termination, he would be temporary partially disabled with temporary work

restrictions precluding pushing, pulling, or lifting over 10 pounds, as well as any overhead work, squatting, kneeling, or prolonged sustained standing or walking.

Treatment Recommendations: Regarding the left shoulder, he should be authorized to undergo arthroscopic surgery with subacromial decompression and repair of the superior labral tear. With regard to the left knee, he should be provided with additional treatment including possible physical therapy, cortisone injections and/or arthroscopic surgery. Excision of the synovial plica was not included. Regarding the right hand, he had symptomatic carpal tunnel syndrome, which might require carpal tunnel release. Should he opt to receive surgical intervention, carpal tunnel should be authorized. Regarding his spine pain, including the cervical, thoracic and lumbar spine, he should be treated symptomatically and with observance of therapeutic measures such as therapy and medication.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

The applicant complained of right thumb numbness and tingling along with cramps. He also had constant burning sensation in the lumbar spine. His lumbar spine pain was rated 8/10. He also had numbness and tingling down his legs. The pain was worse when driving and getting out of the car. He also complained of sharp and burning left knee pain rated 6-7/10. He had cracking and popping along with pressure when crossing his legs. The pain was worse when using stairs. He had constant burning sensation in the cervical spine which was worse with prolonged sitting, lying down, and turning to the right. He had numbness and tingling radiating down his arms with the right side. His present cervical spine pain was rated 7/10.

Diagnoses: 1) Disc protrusion, cervical/lumbar spine. 2) Carpal tunnel syndrome, right wrist.

Treatment Plan: His carpal tunnel surgery was scheduled on [redacted] The postoperative course was discussed. He was prescribed Percocet 5/325 mg and Vistaril 50 mg.

Work Status: He was to remain off work until [redacted]

Request for Authorization, signed by [redacted] D., dated [redacted]

Authorization was requested for MR arthrogram of the left shoulder.

Supplemental Report, signed by [redacted] M.D., dated [redacted]

Subjective Complaints: There was no authorization yet for the MR arthrogram.

Diagnosis: Internal derangement of the left shoulder.

Work Status Report, by [redacted] M.D., [redacted]

The applicant was temporarily totally disabled until [redacted]

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

Subjective Complaints: The applicant's right wrist pain was much better. He only had surgical pain. The numbness and tingling had resolved and his range of motion was good. He complained of constant achy pain in his lumbar spine along with numbness radiating down his legs. He also complained of constant pain in his cervical spine and intermittent burning sensation on his left knee. His right thumb was currently numb due to carpal tunnel surgery however he was no longer feeling spasms and tingling.

Diagnosis: Status post right carpal tunnel release.

Treatment Plan: He was to continue his medications.

Work Status: He remained off work until [redacted]

PR2 for Extended Visit, signed by [redacted] M.D., dated [redacted]

Interim History: The applicant continued to complain of pain in his neck, low back, and left shoulder. He had numbness and tingling in bilateral hands. In the interim, he was seen on [redacted] by Qualified Medical Evaluator, [redacted] M.D.

Diagnoses: 1) Impingement syndrome. 2) Torn labrum. 3) Cervical sprain and strain. 4) Plica syndrome. 5) Carpal tunnel syndrome on the right.

Treatment Plan: Authorization was requested for a shoulder arthroscopy, stabilization of the labrum, durable medical equipment for abduction splint and cold therapy, pre-operative medical clearance, and 12 post-operative physical therapy visits, 3 times a week for 4 weeks.

Doctor's First Report of Occupational Injury or Illness, signed by [redacted], M.D., dated [redacted].

Diagnosis: Left shoulder/upper arm strain.

Treatment Plan: MR arthrogram was requested.

Work Status: The applicant was released to modified work with restrictions of no pushing and no use of the left arm above shoulder level.

Comprehensive Orthopedic Evaluation and Report, signed by [redacted], M.D., dated [redacted]

History of Injury: The applicant was employed by [redacted] from [redacted] at which time he was terminated. During the course of employment on [redacted], he was on a step stool and when he grabbed onto the support on the shelving while stepping down, the support became loose, causing him to lose his balance and hit the left side of his body against the shelve and then falling backwards and twisting while falling and landing face forward. He blacked out for a few seconds and then arose unassisted. He filed a report with the store manager and sat down until the end of his shift. He reported to work the following days, but with pain and swelling. The following Friday, he felt dizzy and had blurry vision. He sought treatment on his own at [redacted] Emergency Room where radiographs and a CT scan were performed. He was diagnosed with post-concussive syndrome and thumb sprain, and was placed on modified work duties. He requested vacation time to recuperate. He returned to work thereafter at modified duty. He came under the care of Dr. [redacted] sometime in [redacted] and was treated with physical therapy for his back, neck, left wrist and knee. He was also referred for neurological evaluation. In the interim, he continued working at modified work duties. He had MRIs and electromyography/nerve conduction velocity studies. He last received treatment for this injury in [redacted]

On [redacted] while lifting a pallet at work, he felt an immediate onset of burning pain on his left shoulder. A report was filed and he was referred for

medical care. He was seen at Concentra and x-rays were performed. Pain medication was prescribed and he was placed on modified work duties. An MRI of the left shoulder was obtained 1 month later. He was subsequently referred to an orthopedic surgeon who discussed surgery for the left shoulder. In late [redacted] he was evaluated by Dr. [redacted] and was prescribed physical therapy for the left shoulder. He also had a CT scan of the left shoulder and left shoulder surgery was again suggested. He was terminated from his employment on [redacted] He last received treatment on [redacted] He was taking over-the-counter medication and was using a topical transdermal and compression to help alleviate the pain.

Present Complaints: He complained of constant pain on his left shoulder, lower back, and left knee. Additional symptoms included continuous pain in his neck which traveled down to his left shoulder blade. He also had numbness and tingling on his right hand. He had occasional headaches associated with neck pain. The pain in his lower back traveled down to his bilateral leg. He had sexual problems due to increased pain in his lower back. He also complained of memory loss and difficulty concentrating.

Social History: He is [redacted] all in good health. He does not smoke or consume alcoholic beverages.

Family History: His parents are living and well. He had [redacted] all in good health.

Occupational History: He was employed with [redacted] from [redacted] at which time he was terminated. He denied gainful employment since that time.

Impression: Left shoulder strain with focal tear of the superior labrum.

Discussion/Causation: The applicant related the onset of his left shoulder symptoms to a specific incident that occurred on [redacted] While lifting a pallet, he felt an immediate onset of burning pain on his left shoulder. He was only authorized by the insurance carrier for evaluation and treatment of the left shoulder. There were multiple orthopedic complaints from his [redacted] injury. In his clinical evaluation, there were positive findings. His left shoulder MRI described a focal tear of the superior labium.

Management: MR arthrogram of the left shoulder was recommended.

Work Status: He was considered to be temporarily partially disabled with restrictions of no use of the left arm at or above shoulder level and no repetitive pulling.

Request for Authorization, signed by [redacted] M.D., dated [redacted]

Authorization was requested for MR arthrogram of the left shoulder.

Fluoroscopic Left Shoulder Joint Injection, signed by [redacted] M.D., dated [redacted]

Impression: Successful injection of the shoulder for MR arthrogram.

MR Arthrogram of the Left Shoulder, signed by [redacted] M.D., dated [redacted]

Impression: 1) Compared to prior examination dated [redacted], the previously described superior labral tear could not be appreciated on the current examination. 2) Mild degenerative changes of the greater tuberosity, unchanged in appearance compared to prior examination. 3) No rotator cuff abnormality was seen.

Qualified Medical Evaluation in Urology Report, signed by [redacted] M.D., dated [redacted]

Chief Complaint/History of Present Illness: The applicant was putting things away overhead on an 8-foot ladder. He grabbed an earthquake reinforcement bar, one side was not screwed down, and he fell down backwards from the top. The second injury occurred while he was lifting a heavy pallet and he felt a burning sensation in his shoulder. It turned out that he had torn his labrum on the left shoulder. The pallet weighed 50 pounds. Because of the injury to his back, he was unable to function the way he used to. He was [redacted] Previously, he would have intercourse 3 times a week, but now, twice a month. He was able to get an erection, able to penetrate, but he was unable to get her wife to orgasm as he could not move the way that he used to due to tightness in his lower back. In addition to that, he complained of premature ejaculation even when he masturbated prior to having intercourse with his spouse. He had not tried Viagra, Levitra, or Cialis. He had tried over-the-counter herbal preparations, but they had

not helped. He did not undergo marriage or family counseling. He saw a psychologist at the beginning of the first injury to check for brain injury and not for depression or erectile dysfunction. He had seen no mental health professional since. An MRI was done on [redacted] and he had a severe reaction to the dye. He had not been seen by an urologist to date.

Work History: He last worked in [redacted] He was terminated because he had violated a safety rule that was just implemented. He was on light duty with restrictions of no heavy lifting over 10 pounds and no standing for over 2 hours. He had worked as a retail worker, replenishing the store, for 8 years. He was in charge of the graveyard shift. He had to do lifting, 95% of the time. The weight ranged from 5 to 70 pounds. Prior to that, he worked at [redacted] doing security for 4 years and at [redacted] doing security for 4 years.

Past Surgical History: He had a vasectomy.

Allergies: He was allergic to gadolinium.

Assessment: 1) Back pain. 2) Erectile dysfunction. 3) Premature ejaculation.

Discussion: The applicant was totally functional, but due to tightness in his back and premature ejaculation, he was unable to satisfy his wife. He had no organic/work-related urological problem. The fact that he was functional and able to get an erection, maintain an erection, and penetrate and orgasm proved that. With patients with back problems causing erectile dysfunction, it was the pain that interfered with their ability to concentrate and maintain the erection. Premature ejaculation was always psychological and there were no psychological reports or psychiatric reports which addressed the applicant's premature ejaculation issue and somehow made it work-related. He did not have a work-related erectile dysfunction problem and all further work up and treatment of his erectile dysfunction needed to be via his non-industrial insurance.

Causation: His erectile dysfunction was not work-related.

Plan: No further workup or treatment of the erectile dysfunction on an industrial basis was indicated. No further evaluation was indicated at this time. No follow-up is needed.

Orthopedic Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

Subjective Complaints: The applicant underwent an MR arthrogram of the left shoulder on [redacted] His pain level had increased.

Diagnoses: 1) Left shoulder strain. 2) Focal tear of the superior labrum of the left shoulder.

Treatment Plan: Physical therapy 2 times a week for 6 weeks was requested. Work conditioning was also requested. He was on temporary partial disability.

Request for Authorization, signed by [redacted] M.D., dated [redacted]

Authorization was requested for work conditioning at 2 times per week for 6 weeks.

Orthopedic Evaluation, signed by [redacted] M.D., dated [redacted]

Chief Complaints: The applicant complained of pain in his neck, right wrist, lower back, and left knee.

History of Present Illness: The applicant had worked as a supervisor for [redacted] since [redacted] He was terminated in [redacted] He was restocking shelves on [redacted] and was on an 8-foot ladder. As he was going down, he held onto a bar that was used to keep the shelves in place. One side of the bar was not bolted down causing him to fall backwards and strike the shelves behind him. He landed on the left side of his body. He injured his right wrist on his way down and struck his left ankle when he landed. He did not report the injury, but did inform his manager. No report was made and he did not seek medical treatment at that time.

On [redacted] he was working his normal shift when he began to feel dizzy and had vertigo. He called his wife and was driven to [redacted] Emergency Room. He had a CT of his brain, as well as x-rays of his lower back, right wrist and left knee. He was also given an ACE bandage for his right wrist.

In [redacted] he saw Dr. [redacted], who prescribed pain medication and ordered an MRI of the lumbar spine as well as an electromyography and nerve conduction

test. Physical therapy was recommended for the right wrist and lower back. He was under Dr. [redacted] care for a year and a half.

On [redacted] he had another incident at work. He was lifting a heavy pallet. After he set the pallet down, he felt a burning pain on his left shoulder. He went to [redacted] Clinic for the left shoulder injury and pain. He saw Dr. [redacted] for the left shoulder injury. After the injury to his left shoulder, he stopped treatment for his cervical spine, lumbar spine, left knee and right wrist.

Past Medical History: He was currently seeing Dr. [redacted] an orthopedist in [redacted] He had no medical problems. He took Advil and Aspirin. He had no known allergies.

Impression: 1) Complaints of neck pain. 2) Complaints of left shoulder pain. 3) Complaints of right wrist pain. 4) Complaints of lower back pain. 5) Complaints of left knee pain.

Recommended Medical Care: He appeared to be unable to work. His temporary disability was extended for 4 weeks.

Progress Report, signed by [redacted] M.D., dated [redacted]

Subjective: The work conditioning was not approved yet. The applicant was doing a home exercise program for his left shoulder.

Diagnoses: 1) Left shoulder strain. 2) Focal tear of the superior labrum, left shoulder.

Treatment Plan: He was on temporary partial disability. Work condition for the shoulder, 2 times a week for 6 weeks was requested.

Orthopedic Panel Qualified Medical Re-evaluation, signed by [redacted] M.D., dated [redacted]

Current Complaints: The applicant complained of pain in his neck, back and left knee. He complained of numbness on his right wrist and hand. He slept 6 to 7 hours per night and woke up 2 times per night. He would take a 30 minute nap. He was suffering from depression. He had not been treated. He was independent

in most activities of daily living. Toileting, walking, climbing stairs, using a phone, housework, laundry, cooking, shopping, sexual activity, and driving caused him pain.

Interval History: He was previously seen on [redacted] at which time he was diagnosed with right knee possible internal derangement. He had not had any new treatment. He had not sustained any injuries since the last evaluation. He was currently taking Advil and Ibuprofen. He was currently not working and had not worked since the last evaluation.

[redacted] 2) Chronic neck pain with multilevel cervical degenerative disk disease without disk herniation. 3) Chronic thoracic sprain/strain with multilevel thoracic degenerative disk disease. 4) Chronic lower back pain with 2 mm L5-S1 disk degeneration on MRI. 5). Right carpal tunnel syndrome, mild, according to electromyography/nerve conduction studies with chronic persistent carpal tunnel symptoms. 6) Left knee contusion with normal MRI on [redacted] with clinical evidence of persistent symptomatic plica. 7) Asymptomatic plica of the right knee, uninjured. 8) Separate injury with-the same employer on [redacted] with a left shoulder injury with MRI evidence of focal superior labral tear, tendonosis and Type II acromion with persistent impingement with a positive MRI finding of [redacted] 9) Sleep disturbance. 10) Possible sexual dysfunction.

Discussion: Since the qualified medical evaluation of [redacted] the applicant was authorized for surgery, but his treating physician was removed from the network. Thereafter, he went through several different doctors and nothing was done since then. He now complained of 2 additional problems. Because of his multiple pain symptoms, he used to be asleep in a prone position, but now he had to sleep on his back. With changes in his sleeping position, he was having sleep apnea and having difficulty with snoring. In addition, he was having some difficulty with sexual function. He was able to achieve an erection, but he could not bring his partner to climax because of his inability to perform due to pain and limitations. He denied he had any further injuries. He had not been employed. Because he required treatment that was not provided for the past 10 months, he continued to remain temporarily disabled and not at maximal medical improvement.

Maximal Medical Improvement Status: He had not reached maximal medical improvement status, mainly because no treatment had been rendered since the qualified medical evaluation of [redacted]

Causation: Causation was unchanged from the qualified medical evaluation of [redacted] With regard to the complaints of sleep disturbance with the applicant now having developed possible sleep apnea and snoring because he had had to alter his sleeping position due to multiple pains, it might be an industrial sleep disturbance. With sexual dysfunction wherein he was having difficulty performing so as to bring his partner to a climax state, this might be industrial sexual dysfunction caused from his multiple injuries resulting from his orthopedic complaints.

Disability Status: He remained temporarily partially disabled.

Work Restrictions: He had a 10 pound and no overhead work, squatting, kneeling, prolonged standing or walking preclusion.

Treatment Recommendations: For the left shoulder, he was still a candidate for arthroscopic surgery with subacromial decompression and repair of the superior labral tear. For the left knee, he still had persistent plica which was symptomatic. The treatment included possible physical therapy, but also he should be authorized for arthroscopic excision if he elected. He was a candidate for a right carpal tunnel release based on his chronic symptomatology. For his cervical, thoracic, and lumbar spine, he could be treated symptomatically, which might include additional physical therapy, chiropractic treatments or acupuncture treatments.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

Subjective Complaints: The applicant complained of numbness on his right thumb. He complained of sharp pain in the lumbar spine.

Diagnoses: 1) Disk protrusion, cervical spine. 2) Disk protrusion, lumbar spine. 3) Carpal tunnel syndrome, right.

Treatment Plan: Authorization would be requested for him to undergo surgery and pre-operative clearance.

Work Status: He remained off work from [redacted]

Request for Authorization, signed by [redacted] M.D., dated [redacted]

Authorization was requested for the applicant to undergo right carpal tunnel release and pre-operative clearance.

Request for Authorization, signed by [redacted] M.D., dated [redacted]

Authorization was requested for pre-operative clearance.

Supplemental Report, signed by [redacted] M.D., dated [redacted]

Assessment: 1) Status post mechanical fall off of an 8-foot ladder on [redacted] 2) Chronic neck pain with multilevel cervical degenerative disk disease without disk herniation. 3) Chronic thoracic sprain/strain with multilevel thoracic degenerative disk disease. 4) Chronic lower back pain with 2 mm L5-Sl disk degeneration. 5) Right carpal tunnel syndrome, mild, with chronic persistent carpal tunnel symptoms. 6) Left knee contusion with normal MRI on [redacted] with clinical evidence of persistent symptomatic plica. 7) Asymptomatic plica of the right knee, un-injured. 8) Separate injury with the same employer on [redacted] with a left shoulder injury with MRI evidence of focal superior labral tear, tendonosis and Type II acromion with persistent impingement with a positive MRI finding of [redacted] 9) Sleep disturbance. 10) Erectile dysfunction and premature ejaculation confirmed by Dr. [redacted] on [redacted] determined non-work related.

Discussion: Dr. [redacted] confirmed back pain and erectile dysfunction and premature ejaculation, but on a non-industrial basis, and recommended work-up and treatment via non-industrial insurance. For the left shoulder arthroscopy, the IMR determination on [redacted] found it to be not medically necessary and appropriate.

Treatment Recommendations: Dr. [redacted] disagreed with the non-certification by the IMR for the left shoulder. The applicant was highly symptomatic. He had objective findings, and based on a thorough physical examination and on the MRIs, he was a surgical candidate. As a Qualified Medical Evaluator, Dr. [redacted] insisted that the surgery be authorized. For the left knee, the applicant could also elect arthroscopic excision. For the right carpal tunnel syndrome, he might consider carpal tunnel

release in the future. For the cervical, thoracic, and lumbar spine, he did not have much in the way of surgical pathology.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

Subjective Complaints: The applicant complained of intermittent pain and burning sensation. He had cracking in the mornings, but denied numbness and tingling. The pain radiated down to his biceps.

Diagnoses: 1) Sprain/strain, left shoulder. 2) Pain, left shoulder.

Treatment Plan: Cortisone injection was administered on his left shoulder. He was recommended to continue with his daily stretching to increase range of motion. He was also to continue taking his medications for pain.

Work Status: He remained off work until [redacted]

Pre-operative Clearance, signed by [redacted] M.D., dated [redacted]

History of Present Illness: The applicant presented for medical clearance for right carpal tunnel release on [redacted] He was injured when he fell off an 8-foot ladder at work. The date of injury was on [redacted] As a result, he injured his right wrist, left knee, back of neck, head and lower back. There was radiation of pain from his lower back down to both legs and from his neck to both shoulder blades. He also had pain in his left knee and numbness of his right wrist. He underwent physical therapy, and pain management for his right wrist and low back. He had a cortisone shot on his left shoulder. After the injection, his arm was stiff and in more pain. He had pain with sleeping, walking, and sitting. The neck and back pain woke him up during the night. He denied chest pain but did have palpitations due to stress with injury. He denied any heart or lung disease. He denied any thrombotic or bleeding disorders.

Allergies: He was allergic to Iodine.

Past Medical History: He had a history of depression.

Family History: His parents are alive. His sister had an ovarian cancer and his mother had hypertension.

Social History: He was on disability. The highest level of education he achieved was college. He had a dog and a cat. He lived in [redacted] with his spouse. He is married with 3 children, all in good health. He never used tobacco. He drinks beer once per day.

Assessment: 1) Sleep apnea, obstructive. 2) Weight gain, abnormal. 3) Depression. 4) Other accidental fall from 1 level to another. 5) Neck pain. 6) Back pain. 7) Carpal tunnel syndrome. 8) Pre-operative examination for right carpal tunnel release. 9) Stable cardiopulmonary examination.

Plan: He was medically stable to proceed with surgery.

Chest X-ray, by [redacted] M.D., dated [redacted]

Conclusion: Normal chest.

[redacted]

Interpretation: Normal sinus rhythm.

Echocardiogram Report, by [redacted] M.D., dated [redacted]

Interpretation: 1) Left ventricular chamber size within normal limits. 2) Normal left ventricular wall motion. 3) Left ventricular wall thickness within normal limits. 4) Left ventricular ejection fraction calculated to be 60-65%. 5) All other cardiac chamber sizes within normal limits. 6) No evidence or pericardial effusion. 7) Normal aortic valve structure with adequate cusp excursion. 8) Normal mitral valve structure with normal opening. 9) Pulmonic and tricuspid valves were not well visualized. 10) A color flow and spectral Doppler study was performed and revealed: a) Trace tricuspid regurgitation. b) Trace aortic insufficiency.

Pulmonary Function Report, Pulmonary Physiology Laboratory, dated [redacted]

Interpretation: There was a mild obstructive lung defect. Because expiratory time to FVC was less than 5 seconds, the degree of obstruction might be underestimated. The airway obstruction was confirmed by the decrease in flow

rate at peak flow and flow at 25%, 50%, 75% of the flow volume curve. There was a mild restrictive lung defect. Diffusion capacity was within normal limits. FEV1 changed by 48%. FEF 25-75 changed by 196%. This was interpreted as a significant response to a bronchodilator.

Laboratory Report, [redacted] Inc., dated [redacted]

AST was within normal limits at 15 as well as ALT at 15, alkaline phosphatase at 66, total bilirubin at 0.7, and creatinine at 0.9. TSH was also normal at 0.413. Hemoglobin was normal at 14.2.

Operative Report, signed by [redacted] M.D., dated [redacted]

Pre-operative and Post-operative Diagnosis: Carpal tunnel syndrome, right.

Title of Operation: 1) Carpal tunnel release, right. 2) Tenosynovectomy of flexor tendons. 3) Saline neurolysis.

Orthopedic Supplemental Report, by [redacted] M.D., dated [redacted]

The applicant was under the care of Dr. [redacted] was no longer authorized to treat the applicant. The applicant was referred to his primary treating physician.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

Subjective Complaints: The applicant complained of constant pain. He felt like his shoulder was going to dislocate. The Cortisone injection administered at his last visit helped for only 2 to 3 days.

Diagnosis: Sprain/strain, left shoulder.

Treatment Plan: He was to start physical therapy.

Work Status: He remained off work until [redacted]

Therapy Prescription, signed by [redacted] M.D., dated [redacted]

The applicant was prescribed physical therapy for the left shoulder, 3 times per week for 4 week.

Request for Authorization, signed by [redacted] M.D., dated [redacted]

Authorization was requested for physical therapy, 3 times per week for 4 weeks.

Primary Treating Physician's Progress Report, signed by [redacted] M.D., dated [redacted]

Subjective Complaints: There was no change in the applicant's symptoms. He was still having some pain and taking Vicodin.

Diagnosis: Sprain/strain, left shoulder.

Treatment Plan: He was to start physical therapy. He remained off work until [redacted]

Orthopedic Re-Evaluation, signed by [redacted] M.D., dated [redacted]

Interval History: The applicant was currently taking Aleve or Advil. He was on temporary disability.

Current Complaints: There was no change in his neck pain and back symptoms. He had pain when he sleeps. He complained of stiffness and soreness, and right wrist numbness. His right hand was also shaking and trembling.

Impression: Status post carpal tunnel release surgery.

Recommended Medical Care: He was to start physical therapy. He was released to modified duty. The estimated maximum medical improvement was 3 to 6 months.

That completes the review of records.

HISTORY OF CONDITION AND ALLEGED CIRCUMSTANCES OF INDUSTRIAL STRESS AND STRAIN (as given by the applicant):

The applicant was hired by [redacted] in [redacted] He started as a retail assistant and later became a supervisor. He was based in the [redacted] store.

He typically worked the night shift, Monday through Friday, 9 pm to 7 am. His duties included accepting deliveries from vendors, restocking the store, assigning employees tasks, and letting employees in and out of the building. He earned [redacted] per hour. His supervisor was [redacted]

He is not currently working. He last worked i[redacted] when he was terminated by [redacted] and [redacted] He did not have concurrent employment while working for [redacted]

The applicant's current source of income is workers' compensation payments of [redacted] per month. He has not applied for Social Security Disability or state disability. His wife is employed as a [redacted] and works with children as autism. She earns approximately [redacted] per month.

Prior to his injuries at [redacted] he did not have any work related injuries.

Prior to his termination, he never had any disciplinary measures. He did not receive any warnings prior to his termination.

A year prior to his termination, he was given a document to sign that stated he would be terminated immediately if he made any errors. The applicant was terminated in [redacted] after he was told that he violated the safety protocol when he climbed on a shelf that was less than a foot off the floor to reach something. He contested the termination with management, but the decision was upheld. He is considering filing a wrongful termination lawsuit with his worker's compensation attorney but has not yet done so.

The applicant was first injured on [redacted] He was putting away merchandise on a ladder in a stock room. He climbed to the top of the ladder with a 30-pound item. On the way down, he reached to grab a reinforcement bar for stability. However, the left side of the bar was not screwed down, and when he

grabbed it, he fell backwards off the ladder from the second rung from the top, approximately seven feet.

During his fall, the back of his head hit the shelves. Additionally, his left knee hit a shelf. He landed on his right side on a concrete floor. He felt the immediate onset of pain to his right side. He also injured the back of his neck and his lower back. He did not immediately seek medical attention. He spoke to the manager about the incident. He continued to work, but then his right hand started swelling and he developed a knot on the back of his head. He was not wearing head protection. This incident was unwitnessed.

After his hand started swelling, he sat down for the remaining one hours of his shift. Then, he went home and took Advil.

Over the next two days, he reported to work. On the second or third day after the incident, he experienced dizziness with visual disturbance while at work. That frightened him so he left work and went to the [redacted] emergency room. After a CT scan, he was diagnosed with concussion, and his hand was wrapped with bandages. However, he was not taken off work.

He then requested a week off from work to rest and attempt to heal. However, this was not helpful.

After taking that week off, the applicant returned to work with self-imposed restrictions. He did not have a doctor's note that he should work with restrictions. He was on self-imposed restrictions for a week or two. He limited himself from heavy lifting, heavy pushing. He continued climbing.

He saw Dr. [redacted], a workers' compensation doctor, who performed evaluations and tests. Dr. [redacted] performed MRIs of the back and wrist. During an MRI, he had a bad reaction to the dye. He felt that his whole body was burning. After this, the applicant was given work restrictions. He denied emotional issues at this time, though Dr. [redacted] reported anxiety, depression, and insomnia. He could not recall telling Dr. [redacted] about emotional difficulties.

He continued treatment with Dr. [redacted] who prescribed unrecalled medications.

The applicant developed dizziness 2-3 days after the incident occurred. He described his dizziness as lightheadedness. He has not had treatment for dizziness.

The applicant also developed headaches. He has not had treatment for his headaches.

He saw a neurologist, Dr. [redacted] on one occasion in [redacted] However, she did not run diagnostic tests. There was no follow up with Dr. [redacted] because she reportedly did not want to set up a follow-up visit.

He had some physical therapy with Dr. [redacted] for his left knee. He could not recall if he had an MRI. No surgery was recommended. The left knee still bothers him, with a burning sensation. It burns four times per month for the whole day at a level of 7/10. There is no plan for further knee treatment.

He had some treatment for the neck, including a "roller" therapy at Dr. [redacted] s office. This was not particularly helpful.

On [redacted] the applicant was again injured. He lifted an 80 pound pallet. He was using more shoulder strength to lift it due to his back pain. He put the pallet down and felt a burning sensation in his left shoulder.

The next day, he felt like someone had hit him in the shoulder. He told the store manager, who sent him to the industrial clinic where tests were performed. He was diagnosed with a torn labrum. He was put on work restrictions of no climbing ladders and no lifting. While he was on restrictions, he did not receive much treatment.

These restrictions were in place until sometime before he was terminated. He asked to be taken off restrictions because he could not do his job with restrictions. He then started climbing on ladders again.

He hired his first attorney prior to the [redacted] injury. He could not recall the attorney's name who was located in [redacted]. He is uncertain of the status of his [redacted] case. He has not received a settlement.

He later switched attorneys to [redacted] who sent him to new doctors. She first sent him to orthopedist Dr. [redacted] He placed the applicant on restrictions in [redacted] Dr. [redacted] recommended surgery. He stopped seeing Dr. [redacted] because he was no longer in the medical provider network and switched to Dr. [redacted] Dr. [redacted] felt he needed physical therapy after reviewing an MRI. Dr. [redacted] did not feel that he required surgery. The applicant no longer sees Dr. [redacted] and he is not sure why not.

Dr. [redacted] is currently his primary treating physician. He provides physical therapy. He also gave him a cortisone shot to the shoulder approximately one month ago. Dr. [redacted] has not recommended left shoulder surgery at this point. He has not been released by Dr. [redacted] He saw Dr. [redacted] last week, and they are trying to get authorization for a cortisone shot for the lower back.

He has been diagnosed with carpal tunnel syndrome and had surgery in [redacted] with Dr. [redacted] Since surgery, the tingling has stopped. However, he still experiences numbness which is expected to improve once his hand is stronger. He has not yet started physical therapy for his hand, but is starting next week.

The applicant began having physical therapy for his shoulder three months ago. His therapist said that his shoulder was frozen. He now has more flexibility and some improvement. However, if has to pull or reach, he has pain.

He has seen Dr. [redacted] an orthopedic QME, once regarding the [redacted] injury. Dr. [redacted] declared him permanent and stationary for the low back in [redacted]. He felt future care should be limited to medications and physical therapy. However, he has not had physical therapy for the low back.

He also saw Dr. [redacted] an orthopedic QME, regarding the [redacted] injury. Dr. [redacted] made diagnosed a left knee condition. He has seen him twice. The applicant has an upcoming visit with Dr. [redacted] in [redacted] In [redacted] Dr. [redacted] also opined that he needed left shoulder surgery, but the applicant was not aware of this. If left shoulder surgery was authorized, the applicant would move forward with it.

The applicant reported that he developed sexual dysfunction secondary to the [redacted] injury, though the claim form has this pleading for both dates of injury. He has a "performance issue" with sex. He is able to become aroused however he experiences premature ejaculation and an inability to satisfy his partner due to the movement limitations associated with his back injury. He reported that this problem began with the [redacted] injury. Because of the sexual issues, he reported that there has been conflict with his wife. He saw urology QME Dr. [redacted] once for sexual dysfunction. The applicant reported that Dr. [redacted] did not feel he had a urological problem.

Overall, the applicant feels that he is not receiving adequate medical treatment.

Regarding the psychiatric claim, the applicant reported that he developed emotional symptoms soon after the [redacted] injury. The applicant reported that his injuries have affected him emotionally because he cannot do the daily work he used to perform at [redacted] as 90% of the job was climbing on a ladder. He worries that he cannot get a job like that again. This has caused him to change his focus on his career.

He feels depressed. He is primarily concerned about the marital issues due to his sexual dysfunction which began approximately six months after the [redacted] injury. She has expressed disappointment and is less patient with him. She is generally upset due to the sexual issues. Prior to his injuries, they were intimate four times per week and he could get his wife to climax. After the injury, they were intimate once per month, and he is unable to get her to climax. He does not feel that she is unfaithful, but he is concerned that she might be in the future. This contributes to his depression. The sexual problem is the primary problem in his marital relationship. He feels that his wife would be better off with someone else. He became tearful as he related this.

He is sad that he cannot do certain things with his kids, such as bicycling or going to the beach. Bicycling causes back pain. He cannot play tag or volleyball with them at the beach, though he does accompany them.

He regards his [redacted] heritage as a contributor to his lack of expressiveness about his emotional condition. He does not want to "look weak."

His sleep is affected. He is a stomach sleeper, but now he cannot sleep on his stomach due to the shoulder injury. He must sleep on his back. He also snores which wakes him up. He was reportedly diagnosed with sleep apnea in the course of a physical for his hand surgery. He is considering getting a sleep study. He has not been prescribed any treatment for sleep apnea.

He denied pre-existing sleep difficulties. He used to get 6-7 hours of sleep per night. Since his injury, he has been sleeping 5 hours per night. He can fall asleep without difficulty, but wakes up twice per night every night due to his back pain and needing to reposition. It takes 20 minutes to fall back asleep. He denied early morning awakening.

He worries frequently. He worries about his car problems, his marriage, his kids' education, and his own education. He does not find it difficult to control the worries.

He reported irritability. Two years ago, his children were complaining that he was upset all the time. At the time, he didn't realize that, due to his injuries, he was more irritable. He related this to his sleep problems. He would get upset and yell at his children when he later felt he should not have. He is yelling about once a week. He is set off by bad drivers. He expresses his anger at drivers by yelling and flipping them off. He has not gotten out of the car to confront anyone.

He frequently yells at the dog. The kids do not want to take the dog out, so the applicant needs to take him out at midnight sometimes. He does not become violent, throw things, or break things when he is upset.

The applicant's termination affected him emotionally. He felt that he was an asset to the company and felt betrayed by his termination. He felt they were trying to get rid of him due to his injuries, though he was loyal to the company. He thinks about his termination about three times per year.

He denied low energy, feelings of guilt, or appetite problems. He weighs approximately [redacted]. His weight has been stable since his injuries.

He denied concentration problems. He is able to study. He is currently enrolled in courses at [redacted] college and his grades are "good." He is currently earning As. However, sitting for a long period of time affects studying due to his back pain.

He does not use recreational drugs. In terms of alcohol, he has a beer or two once per year. He has never had a drug or alcohol problem in the past.

He denied thoughts of harming himself or others. He denied auditory or visual hallucinations. He denied panic attacks.

He has not sought treatment for his anxiety and depression due to his finances. His attorney has not referred him for mental health treatment. Were he referred for therapy and/or medication, he would be interested in pursuing that treatment.

In terms of the future, he is planning to get an education and start a new career. He has not looked for work. He is currently a student at [redacted] College where he is taking a general curriculum to get an associate's degree. He plans to transfer to a University of [redacted] system school. He wants to get into computer programming.

CURRENT CONDITION

Currently, his neck and low back bother him the most. He continues to have low back pain on a daily basis at a level of 9/10.

He continues to have dizziness. If he sleeps "wrong "on his neck and it gets stiff or he turns too quickly, he becomes dizzy. This occurs twice per week for two minutes at a time. It affects his ability to drive. He has had to pull over twice due to dizziness.

Headaches are ongoing and occur three times a week for two hours at a level of 8/10.

The swelling in his right hand resolved however he still experiences numbness.

He continues to have neck pain every day at a level of 5/10.

He continues to have left shoulder symptoms when he sleeps. He cannot sleep on his left side due to stabbing pain at a level of 8/10. Walking the dog is also difficult with his left hand, because when the dog pulls, it hurts his shoulder. Reaching overhead is also painful.

He continues to experience sexual dysfunction. He is able to become aroused, but continues to have premature ejaculation and performance problems as described in detail above.

His left knee pain is bothersome, but more tolerable. It has a burning sensation. It burns four times per month for the whole day at a level of 7/10.

Emotionally, the applicant reported current symptoms of depression, sexual dysfunction, marital dysfunction, sadness, sleep difficulties, worry, irritability, and rumination.

CONCURRENT STRESSORS

The applicant denied financial stress. He has $[redacted] in credit card debt, but the debt is not in collections. However, he is frequently late on his rent. They run about 10-15 days late. He has not been threatened with eviction as he reports that his landlord is understanding. He has not filed for bankruptcy, had items repossessed, or had services shut off.

His wife does not have physical or emotional problems. He has never been separated from his wife. There has not been domestic violence. They have had marital difficulties due to his sexual dysfunction, as she has been upset by his inability to perform.

Additionally, he was unfaithful prior to the marriage, near the beginning of the relationship. This was approximately 17 years ago. They resolved the issue, though it comes up infrequently. She is not suspicious that he is currently unfaithful. There is trust in the relationship. She has never been unfaithful.

He and his wife have discussed divorce in relation to his arguing with the children due to his irritability, but not due to his sexual problems. They disagree on parenting. Additionally, his parents and her parents disagree on how to raise the children . There are religious conflicts as he is [redacted] and his wife is [redacted]. He reports that his family is judgmental and frequently interjects their religious beliefs regarding the fact that he is not raising his children in a traditionally [redacted] manner. For instance, his children were not baptized and this has caused conflict.

The applicant's [redacted] and a student at [redacted] College. This [redacted] and is technically his [redacted] The applicant reported a good relationship with his [redacted]

His [redacted] He does not have behavioral, medical, or legal problems. He is reportedly doing well.

His [redacted] is mildly autistic. Her speech and communication are affected. She cannot pronounce some words properly. She talks to herself and repeats things a lot. She does not have behavioral problems and is not violent. She is in special classes, has an IEP, and also has a therapist and a behaviorist. She was, but is no longer, a [redacted] client.

The applicant acknowledged some stress from his autistic daughter's condition. The applicant has dealt with her autism "okay," but he is concerned for her future. He feels that she is "a lovely kid," her siblings love her, and they figure out ways to communicate with her. It has been a challenge, but he is generally coping. He is involved with her school and care. He takes her to speech therapy and takes her to school and picks her up. He talks to her teachers and helps her with homework. He also takes her on playdates.

He has been married once. He married his wife at age[redacted] His wife is[redacted] and practices[redacted] She is not[redacted] The applicant grew up[redacted] but he is not a practicing[redacted] There is religious conflict between the families, so they do not get together for family gatherings. The children are being raised[redacted] His wife takes the children to temple on occasion. He does not go with her. They keep[redacted] and he participates sometimes to some extent. He has not learned the[redacted] prayers. His mother wants the children to be baptized[redacted] She thinks it is "sinful" that they are being raised[redacted] This causes conflicts as his sisters also interject themselves and pressure him to get his children baptized.

His parents do not have relationships with his children and this bothers him. His mother has reportedly "crossed the line" with religious issues and lacks boundaries. This conflict has existed since the start of the marriage.

His wife's mother lives in the area. She and the applicant do not get along. She reportedly kicked him out of her house when he was picking up his[redacted]. His mother-in-law does not think that he should be involved in her upbringing, as he is not her biological father. He tries not to engage with his mother-in-law.

He denied that anyone close to him has died or become seriously ill since he has been injured.

He denied other sources of stress in his life since his injury.

CURRENT TREATMENT

He is currently treating regularly with Dr.[redacted] an orthopedist, who is his primary treating physician. He began physical therapy three weeks ago and authorization for another cortisone shot has been requested.

CURRENT ACTIVITIES

The applicant wakes at up at 6:15 am. He wakes up his[redacted] and helps her get into the shower. She is independent with showering, dressing, toileting, and hygiene, but he helps her brush her hair. He gets dressed. He makes his children's lunches. He showers daily. He takes the dog out. He drives the children to two different schools which takes an hour round trip. He stays at his daughter's school until the behaviorist arrives. Then he goes home and gets ready

to attend school himself or takes his daughter to class. He goes to school three times per week for two hours and three hours on the weekends. When he is not at school, he helps his kids with their homework.

He is independent with his own ADLs including showering, grooming, feeding, toileting, and hygiene.

For fun, the applicant may go to the movies or a museum. However, financial issues have prohibited this as well as fatigue and pain when walking. He does not have hobbies.

His wife cooks. His wife and kids clean. The kids do their own laundry. His wife does the other laundry. He gets the groceries. He does not do yardwork. On the weekends, he stays home.

He has friends but he does not see or speak with them frequently partly due to his financial concerns and partly because they are not married and "doing their own thing." They do not have many get-togethers. He has not made friends at school. The students are generally significantly younger than he is.

He has not traveled since his injuries. His family is thinking about going on a tourist trip to [redacted] before the end of the year. They have not made specific travel plans yet.

He does not go to church, though his parents want him to go to church.

PAST PSYCHIATRIC HISTORY

The applicant denied a history of past similar symptoms, psychiatric hospitalizations, diagnosis, treatment history, therapy, other psychotropic medication trials, 12-step programs, or suicide attempts.

FAMILY HISTORY

The applicant denied a family history of past psychiatric hospitalizations, diagnosis, treatment history, therapy, psychotropic medication trials, 12-step programs, or suicide attempts.

SOCIAL HISTORY

The applicant was born in [redacted]. He was raised in [redacted] where he arrived as an infant. He was raised in [redacted] near [redacted]. His mother and father raised him. They were married. His mother was his primary caretaker.

He denied physical and sexual abuse as a child.

He has [redacted].

He grew up in a "rough" neighborhood. There was gang violence around the neighborhood, though the applicant was not in a gang. He saw gang fights, including shootings. He saw people get shot. A friend of his was shot, which made the applicant sad, but his friend recovered. Another friend was murdered, but he did not witness this. The applicant was never shot at. He did have to defend himself, but did not have to use a weapon. Overall, he did not fear for his safety growing up and denies any psychiatric residuals from the violence he witnessed in his youth.

He arrived in the US without documentation. He became a legal resident in approximately [redacted]. All his family members are citizens except for him and his mother. He has not yet applied for citizenship. He thinks eventually he will become a citizen.

His wife is a citizen.

He completed a GED in approximately [redacted] He left high school 3-4 months before graduation to work in a shoe factory with his father.

His father is alive and [redacted] years old. He continues to work in the shoe business. He lives in [redacted] and he is healthy. Their relationship is good. They talk once per month.

His mother is alive and [redacted] years old. She is healthy. She does not work and has been a homemaker. Their relationship is good, and they speak once per week by phone.

As described above, the applicant has been once married once at age [redacted]. He met his wife at the [redacted]. There was a period of infidelity on his part [redacted] years ago which they resolved. She has not been unfaithful.

The applicant considers himself to have three children, and raises three, but he is only the biological father of two of them. The [redacted] has a different father. His name is [redacted] and he does not live in the country. [redacted] is not involved with the family. This has not affected the family or their marriage. He does not have any other children with other women.

He was arrested once, at the age of approximately [redacted] for misdemeanor theft of video games. He was in jail for one day. He had to do community service and pay restitution. The arrest was expunged. He denied DUIs or other arrests.

He has never been in the military. He denied other legal issues apart from his worker's compensation claim.

OCCUPATIONAL HISTORY

Prior to [redacted] he worked at [redacted] as a [redacted] for [redacted] years. He left that job because the company he was working with lost the [redacted] contract. Prior to that, he worked at [redacted] for six months to a year, but left to work at [redacted] Before that, he worked as a [redacted] at [redacted] for [redacted] years, and left that job for better employment at [redacted]

He has never been terminated from another job besides [redacted]

MEDICAL HISTORY

The applicant had left eye surgery at age 9 to address a pterygium. He does not have residuals.

He was diagnosed with sleep apnea in the course of a physical for his carpal tunnel surgery. He is considering getting a sleep study. He has not been prescribed treatment for sleep apnea.

He denied a history of hypertension or diabetes.

The applicant went to the emergency room in [redacted] for a kidney stone, and was in the hospital for one day. The stone passed. He has not had a recurrence of kidney stones. He does not know why he developed a stone. He was not given dietary restrictions. He is not concerned about redeveloping kidney stones.

He was in a motor vehicle accident at the age of 21 when a car pulled out in front of the car he was in as a passenger. The driver swerved to miss it, and the car hit a tree. They were going 20 mph at the time of impact. Nobody, including the applicant, was injured. There were no legal repercussions. This accident did not cause emotional or legal problems.

CURRENT MEDICATIONS

The applicant currently takes the following medications:

Advil (over-the counter), four times a week, dose unknown.

Aleve (over-the counter), 3-4 times per week, dose unknown.

PSYCHIATRIC DIAGNOSTIC TESTING

BECK ANXIETY INVENTORY: 18 - Moderate Anxiety

The Beck Anxiety Inventory is a 21-question self-report inventory which asks the applicant to choose from a hierarchy of levels of anxiety-related symptomatology for each question. This is a self-rating device to delineate the nature, intensity and frequency of anxiety-related symptomatology. Each question is scored from zero to three, with a maximum score of 63 for the test. The higher the score the higher the self-rating by the applicant as a measure of anxiety-related symptoms.

0 – 7	Minimal anxiety
8 – 15	Mild anxiety
16 – 25	**Moderate anxiety**
26+	Severe anxiety

BECK DEPRESSION INVENTORY: 29 - Moderate Depression

The Beck Depression Inventory (BDI) is a 21-question self-report inventory which asks the applicant to choose from a hierarchy of levels of depressive symptomatology for each question. This is a self-rating device to delineate the nature, intensity and frequency of depressive symptomatology. Each question is scored from zero to three, with maximum score of 63 for the test. The higher the score, the higher self-rating by the applicant as a measure of depressive symptoms.

0 - 9	Minimal depression
10 – 18	Mild depression
19 – 29	**Moderate depression**
30+	Severe depression

HAMILTON PSYCHIATRIC RATING SCALE FOR ANXIETY
11 - Mild

The Hamilton Rating Scale for Anxiety emphasizes the somatic, or bodily, symptoms of anxiety which include cardiac, respiratory, and gastrointestinal symptoms. Therefore, it is the most objective measure of symptoms of anxiety.

0 – 7	None/Minimal Anxiety
8 – 17	**Mild**
18 – 24	Moderate
25+	Severe

HAMILTON PSYCHIATRIC RATING SCALE FOR DEPRESSION
13 - Mild

The test was developed by Dr. Hamilton, and is not a "self-rating" test. Rather, applicants discuss their responses with the physician who rates their degree of depression and/or anxiety. Both are considered the most objective measure of an applicant's degree of depression and/or anxiety. Scores to determine the degree of depression and anxiety vary by clinician. The Hamilton Rating Scale for Depression is the most commonly-used psychiatric test in psychiatric pharmacologic management and in research studies because of its objectivity. This test emphasizes vegetative depressive symptoms – such as sleep and sexual disturbance – in contrast to the Beck Depression Inventory which emphasizes affective, cognitive and vegetative symptoms. The Hamilton Rating Scale for Depression is used extensively to measure clinical improvement in levels of depression, and an antidepressant is considered efficacious if it results in 50% reduction in the applicant's scores on this test.

0 – 7	None/Minimal Depression
8 – 13	**Mild**
14 – 18	Moderate
19 - 22	Severe
23+	Very Severe

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY – 2

PROFILE VALIDITY

His MMPI-2 clinical profile is probably valid. The client's responses to the MMPI-2 validity items suggest that he cooperated with the evaluation enough to provide useful interpretive information. The resulting clinical profile is an adequate indication of his present personality functioning.

SYMPTOMATIC PATTERNS

The clinical scale prototype used to develop this report incorporates correlates of Hs and Hy. Because these scales are not well defined in the clinical profile (the highest scales are relatively close in elevation), interpretation of the clinical profile should not ignore the adjacent scales in the profile code. His MMPI-2 clinical profile presents a rather mixed pattern of symptoms in which somatic reactivity under stress is a primary difficulty. The client presents a picture of physical problems and a reduced level of psychological functioning. The client is likely to have a hysteroid adjustment to life and may experience periods of exacerbated symptom development under stress. Some individuals with this profile develop patterns of "invalidism" in which they become incapacitated and dependent on others. His physical complaints may be vague, may have appeared suddenly after a period of stress, and may not be traceable to actual organic changes. He may be manifesting fatigue, vague pain, weakness, or unexplained periods of dizziness. He may view himself as highly virtuous and he may show a "Pollyannish" attitude toward life. Such clients may not appear greatly anxious or depressed about their symptoms and may exhibit "la belle indifference." Apparently sociable and rather exhibitionistic, this individual seems to manage conflict by excessive denial and repression. In addition, the following description is suggested by the client's scores on the content scales. He views his physical health as failing and reports numerous somatic concerns. He feels that life is no longer worthwhile and that he is losing control of his thought processes. According to his response content, there is a strong possibility that he has seriously contemplated suicide.

PROFILE FREQUENCY

It is usually valuable in MMPI-2 clinical profile interpretation to consider the relative frequency of a given profile pattern in various settings. The client's MMPI-2 high-point clinical scale score (Hy) was found in 12.1% of the MMPI-2 normative sample of men. However, only 3.8% of the normative men had Hy as

the peak score at or above a T score of 65, and only 2.3% had well-defined Hy spikes. This elevated MMPI-2 profile configuration (1-3/3-1) is rare in samples of normals, occurring in 1.8% of the MMPI-2 normative sample of men. The relative frequency of this profile in various outpatient settings is informative. In the Pearson outpatient sample, this MMPI-2 high-point clinical scale score (Hy) occurred in 15.9% of the males. Moreover, 9.1% of the male outpatients had the Hy scale spike at or above a T score of 65, and 5.1% had well-defined Hy scores. His MMPI-2 profile configuration (1-3/3-1), in this elevation range, is the most frequent two-point code in samples of male outpatient psychiatric patients. This configuration occurred in 5.1% of the Pearson male outpatient sample.

PROFILE STABILITY

The relative elevation of his highest clinical scale scores suggests some lack of clarity in profile definition. Although his most elevated clinical scales are likely to be present in his profile pattern if he is retested at a later date, there could be some shifting of the most prominent scale elevations in the profile code. The difference between the profile type used to develop the present report (involving Hs and Hy) and the next highest scale in the profile code was 4 points. So, for example, if the client is tested at a later date, his profile might involve more behavioral elements related to elevations on D. If so, then on retesting, pronounced complaints of depressed mood and low morale might become more prominent.

INTERPERSONAL RELATIONS

Individuals with similar profiles tend to be somewhat passive-dependent and demanding in interpersonal relationships. The client may attempt to control others by complaining of physical symptoms. He is likely to experience low sexual drive and may have problems in his marriage because of this. He seems to require an excessive amount of emotional support from his spouse. His physical complaints are likely to be used to gain attention for his perceived illness. The client's scores on the content scales suggest the following additional information concerning his interpersonal relations. He tends to approach social relationships with some caution and skepticism.

DIAGNOSTIC CONSIDERATIONS

Individuals with this profile typically exhibit a neurotic pattern of adjustment and would probably receive a clinical diagnosis of Conversion Disorder or Somatization Disorder. They might also receive an Axis II diagnosis of Dependent Personality.

TREATMENT CONSIDERATIONS

The client will probably be resistant to mental health treatment because he has little psychological insight and seeks medical explanations for his disorder. He is probably defensive and reluctant to engage in self-exploration. In addition, he seems to experience little anxiety over his situation and may have little motivation to change his behavior. Some individuals with this profile respond to placebos or mild suggestion or to stress inoculation training if it is not too threatening. They will probably require long-term commitment to therapy before their personality will change substantially. However, individuals with this profile often terminate treatment early.

MENTAL STATUS EXAMINATION

The applicant is a [redacted]-year-old [redacted] man who appears younger than his chronological age. He was well-groomed. He wore jeans, a plaid long-sleeve shirt, and sneakers.

He demonstrated pain behaviors on exam. He sat on the edge of the couch and frequently shifted. He reported that his back and shoulder were "burning" during the exam.

Upon presentation, the applicant asked for the examiner's identification to verify that I was truly the doctor. This was provided and the applicant was satisfied. The applicant was cooperative and attentive for the remainder of the examination. He did not appear suspicious or guarded. He made good eye contact throughout the evaluation. He was a moderate historian. He had some difficulty recalling details, even upon prompting. Though he could not recall some details of his history and treatment, he recalled a reasonable amount of detail regarding his history, condition, and treatment.

His speech was spontaneous and generally fluent. There was no evidence of dysarthria. His speech was normal with regard to rate, volume, and tone. However, he demonstrated hypophonia when discussing his emotional problems. His thought process was linear. He denied current suicidal or homicidal ideation. He denied

auditory or visual hallucinations. There was generally no evidence of psychosis.

His affect was restricted and reflected anxiety and depression. He had a furrowed brow. His stated mood was sad. Affect and mood were appropriate to conversational content. He was tearful when discussing his marital difficulties. He was well-related overall. He was oriented times four. Memory, focus, and concentration were grossly intact. General intellectual skills appear to fall in the average range. Insight is good, and judgment is good.

DIAGNOSIS (DSM-IV-TR)

Axis I	Clinical Psychiatric Syndrome and Other Conditions:
309.25	Adjustment Disorder with Mixed Anxiety and Depression, Chronic
Axis II	Personality and Specific Developmental Disorders:
V71.09	No Diagnosis
Axis III	Description of Physical Disorders:
	Deferred to the appropriate specialists.
Axis IV	Severity of Psychosocial Stressors.
Axis V	CURRENT GAF: 62 with corresponding WPI of 12.

Explanation of GAF Ratings:

91-100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
81 – 90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
71 – 80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational or general functioning (e.g. temporarily falling behind in school work).
61 – 70	**Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functions (e.g. occasional truancy, or theft within the household) but**

generally functioning pretty well, has some meaningful interpersonal relationships.

51 – 60 Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or coworkers).

41 – 50 Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).

31 – 40 Some impairments in reality testing or communications (e.g., speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relationship, judgment, thinking, or mood (e.g. depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant in home and is failing at school).

21 – 30 Behavior is considerably influenced by delusions or hallucinations OR serious impairments in communication or judgment (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day, no job, home or friends).

11 – 20 Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent; manic excitement) OR occasionally fails to main minimal personal hygiene (e.g. smears feces) OR gross impairment in communication (e.g. largely incoherent or mute).

1 – 10 Persistent dangerous of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

LEVELS OF PERMANENT MENTAL IMPAIRMENT

As identified in Table 14-1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

Class 1. No Impairment
Class 2. Mild Permanent Impairment
Class 3. Moderate Permanent Impairment
Class 4. Marked Permanent Impairment
Class 5. Extreme Permanent Impairment
D Deferred until MMI

1. Activities of Daily Living

D	Self-care personal hygiene (urinating, defecating, brushing teeth, combing hair, dressing oneself, bathing, eating, preparing meals, and feeding oneself)
D	Communication (writing, typing, seeing, hearing, speaking)
D	Physical activity (standing, sitting, reclining, walking, climbing stairs)
D	Travel (driving, riding, flying)
D	Nonspecialized hand activities (grasping, lifting, tactile discrimination)
D	Sexual function (orgasm, ejaculation, lubrication, erection)
D	Sleep (restful, nocturnal sleep pattern)

2. Social Functioning

D	Gets along well with others
D	Initiates social contacts
D	Communicates clearly with others
D	Interacts and actively participates in group activities
D	Cooperative behavior, consideration of others, and awareness of others' sensitivities
D	Interacts appropriately with the general public
D	Asks simple questions or requests assistance
D	Accepts instructions and responds appropriately to criticism from supervisors
D	Gets along with coworkers and peers without distracting them or exhibiting behavioral extremes
D	Maintains socially appropriate behavior
D	Adheres to basic standards of neatness and cleanliness

3. Memory, Concentration, Persistence, and Pace

D	Comprehends, Persistence, and Pace
D	Works with or near others without being distracted
D	Sustains an ordinary routine without special supervision
D	Ability to carry out detailed instructions
D	Maintains attention and concentration for specific tasks
D	Makes simple work-related decisions
D	Performs activities within a given schedule
D	Maintains regular attendance and is punctual within customary tolerances
D	Completes a normal workday and workweek without interruptions from psychologically based symptoms

4. Deterioration or Decompensation in Complex or Work Life Settings (Adaptation to Stressful Circumstances)

D	Withdraws from the situation or experiences exacerbation of signs and symptoms of mental disorder
D	Decompensates and has difficulty maintaining performance of activities of daily living (ADL's,) continuing social relationships, or completing tasks
D	Able to make good autonomous decisions/exercises good judgment
D	Performs activities on schedule
D	Interacts appropriately with supervisors and peers
D	Responds appropriately to changes in work settings
D	Aware of normal hazards and takes appropriate precautions
D	Able to use public transportation and can travel to and within unfamiliar places
D	Sets realistic goals
D	Makes plans independent of others

OVERALL PERMANENT IMPAIRMENT RATING: Deferred until MMI.

DISCUSSION

Summary of Issues and Injuries:

[redacted] is a [redacted]-year-old married [redacted] man who lives in [redacted] in a townhouse that he rents. He lives with his [redacted] and their [redacted]). He drove himself to the evaluation.

He is claiming injury to his upper extremities, head, knee, neck and back, psyche, and sexual function stemming from an injury on [redacted] Additionally, he is claiming injury to his left shoulder, psyche, sleep function, and urological function stemming from an injury on [redacted]

The applicant was hired by [redacted] in [redacted] at the [redacted] store. He started as a retail assistant, and later, became a supervisor. Prior to his injuries at [redacted] he did not have any work related injuries. He last worked [redacted] when he was terminated for a safety violation of stepping on a low shelf. Prior to his termination, he never had any disciplinary measures. He did not receive any warnings prior to his termination. He is considering filing a wrongful termination lawsuit.

The applicant's source of income is workers' compensation payments of [redacted] per month. Moreover, his wife earns approximately [redacted] per month.

The applicant has two dates of injury. He was first injured on [redacted] when he fell off a ladder approximately seven feet to the floor, hitting his head and left knee on the way down. He felt the immediate onset of pain in his right side, including his neck and low back. He did not seek immediate treatment, but sat down for the remainder of his shift and took Advil at home. Two days later, he experienced dizziness with visual disturbance and sought evaluation at the [redacted] emergency room. He was diagnosed with a concussion and took a week off work in an attempt to recover. He returned to work with self-imposed restrictions for a week or two of limiting heavy lifting and heavy pushing.

He saw Dr. [redacted], a workers' compensation doctor, who ordered MRIs of the back and wrist. He denied emotional issues at this time, though Dr. [redacted] reported anxiety, depression, and insomnia.

The applicant developed dizziness and headaches, and was evaluated by neurologist Dr. [redacted] who did not prescribe any treatment. He had some physical therapy with Dr. [redacted] for his left knee and neck. His knee improved somewhat. His neck did not.

The applicant also developed sexual dysfunction secondary to the [redacted] injury including premature ejaculation and performance problems due to his limited mobility. He saw Dr. [redacted] the QME in urology who opined that his condition was not industrial.

On [redacted] the applicant was again injured when he injured his left shoulder while lifting an 80-pound pallet. He was sent to an industrial clinic and diagnosed with torn labrum. He saw orthopedic QME Dr. [redacted] who recommended shoulder surgery. He was also put on work restrictions of no climbing ladders and no lifting. These restrictions were in place until sometime before he was terminated, but he asked to be taken off restrictions because he could not do his job. Dr. [redacted] placed the applicant on restrictions in [redacted] after his termination. He saw Dr. [redacted] who felt he needed physical therapy.

He currently sees Dr. [redacted] as his primary treating physician. He provides physical therapy which started three months ago and cortisone shots. Dr. [redacted] has not released him. He has some improvement in his shoulder function.

Dr. [redacted] an orthopedic QME, declared him permanent and stationary for his [redacted] injury. He felt he should have future care of medications and physical therapy. However, he has not had physical therapy for the low back.

He also saw Dr. [redacted] an orthopedic QME, regarding the [redacted] injury. Dr. [redacted] also opined that he needed left shoulder surgery. If the left shoulder surgery was authorized, he would move forward with it.

He underwent carpal tunnel surgery in [redacted] with Dr. [redacted] His symptoms have improved somewhat. In the course of evaluation for this surgery, he was diagnosed with sleep apnea, for which he has not yet received treatment.

According to the applicant, his emotional symptoms began after the [redacted] injury. He developed symptoms of depression, sexual dysfunction, marital dysfunction, sadness, sleep difficulties, worry, concentration difficulties due to pain, irritability,

and rumination. The applicant's termination affected him emotionally. He felt betrayed by his termination.

He has not sought treatment for his anxiety and depression due to his finances. His attorney has not referred him for mental health treatment. Were he referred for therapy and/or medication, he would be interested in pursuing that treatment.

With regard to his future plan, he is currently a student at [redacted] College, taking a general curriculum with a goal of an associate's degree. He plans to transfer to a [redacted] system school for computer programming.

Summary of Reported Symptoms:

Currently, the applicant reports current symptoms of depression, sexual dysfunction, marital dysfunction, sadness, sleep difficulties, worry, concentration difficulties due to pain, irritability, and rumination.

Summary of Treatment:

He has not undergone mental health evaluation or treatment, nor has he been referred for it.

Summary of Past Psychiatric/Psychological Treatment:

The applicant denied a history of past mental health symptoms or treatment.

Summary of Outside Stressors:

During the current evaluation, the applicant reported the following outside stressors:

He has marital difficulties related to his sexual dysfunction, irritability, and religious conflicts.

He has conflicts with his family and his wife's family regarding their religious differences [redacted]

He does not get along with his mother-in-law and tries to avoid her.

Moreover, his mother has crossed boundaries with regard to religious activities,

and his parents do not have a relationship with his children. This is a source of distress to him.

His daughter has autism with communication difficulties, and he is stressed by her condition and worried about her future.

Discussion of Records Reviewed:

The applicant's report was generally consistent with available records. Records generally corroborate his report.

On [redacted] he sought treatment at the [redacted] emergency room. He was diagnosed with Post concussive syndrome and thumb sprain. An accompanying form from Dr. Tsou indicates he could return to work on [redacted] then work with restrictions. The applicant indicated that he was not taken off work after the injury, but took off time on his own to recover.

He first saw Dr. [redacted] on [redacted] He reported that he sustained a specific injury to his head, neck, right wrist, right thumb, low back, and left knee during the course of his employment for [redacted] and [redacted] as a supervisor. The applicant complained of constant, recurrent headaches associated with nausea, dizziness, memory problems, problems focusing, vision problems, and right upper extremity, back, and neck pain. He reported depression, anxiety, and sleep difficulties.

On [redacted] he saw Dr. [redacted] in neurology consultation. She diagnosed status post closed head injury with posttraumatic head syndrome; depressive mood,; Cervical and lumbosacral strain; Status post contusion of the left knee with residual pain; and Rule out right carpal tunnel syndrome. Fioricet and Meclizine 25 mg were prescribed to be taken on an as-needed basis. EEG as well as nerve conduction velocity and electromyography study of the right upper extremity were ordered. The applicant reported that he saw Dr. [redacted] once and did not undergo EEG or nerve conduction studies.

The applicant was deposed on [redacted] His narrative of his history, injuries, and treatment (prior to his [redacted] injury) is generally consistent with that provided during the current exam. He reported a prior position at [redacted] though he did not report that employment on current exam. He reported a prior MVA in which he was at fault, but he did not report that on current exam.

On [redacted] he saw Dr. [redacted] after a shoulder injury. The applicant's left shoulder was still sore. It popped when he moved it around. He developed pain in his left shoulder after moving a pallet. Left biceps tendinitis/shoulder sprain was diagnosed. Physical therapy 3 times per week for 2 weeks was recommended. He was precluded from lifting items weighing over 25 pounds as well as overhead reaching. Associated records indicate that he attended physical therapy.

On [redacted] he saw Dr. [redacted] for an orthopedic QME in association with the [redacted] injury. His report of the injury and subsequent treatment and symptoms is generally consistent with current applicant report. It is noted that the applicant complained of depression. The applicant's present condition relative to his right thumb, right wrist, neck, mid back, low back, and left knee was industrially related and secondary to the accident on [redacted] His condition became permanent and stationary three months prior to this evaluation as his complaints had remained essentially the same for the past three months. Based on the lumbar MRI report on [redacted] he had a permanent work restriction precluding very heavy lifting. There was no need for provision for surgery on an industrial basis, only conservative care. There was no basis for apportionment. This is generally consistent with applicant report.

He saw a number of physical therapists and orthopedic providers in the interim, particularly with respect to his shoulder condition. He remained on work restrictions. He complained of difficulty climbing ladders.

On [redacted] he saw Dr. [redacted] in orthopedic consultation with respect to his [redacted] injury. Dr. [redacted] diagnosed traumatic impingement syndrome and distal clavicle arthrosis and superior labral tear in the left shoulder. He was recommended to have an arthroscopic acromioplasty, distal clavicle resection, and labral repair. The applicant stated he would like to have this surgery. The applicant did not have this recommended shoulder surgery.

On [redacted] he saw Dr. [redacted] The report of his [redacted] injuries was generally consistent with current applicant report. After his injuries, he developed constant headaches, light headedness, episodes of short term memory loss, anxiety, and stress. He also developed sexual dysfunction due to his lower back pain. He had not received any treatment for these complaints. He complained of anxiety and stress due to his pain. He had difficulty maintaining an erection. He had difficulty sleeping and he would awaken with pain and discomfort. Dr. [redacted] diagnosed herniated nucleus pulposus, cervical spine; cervical sprain and strain; and torn labrum, left shoulder. Causation was industrial.

He was not yet at MMI. A home strengthening program was recommended. Should the applicant's symptoms not abate, MR arthrogram of the left shoulder and/or arthroscopic evaluation of the left shoulder on an industrial basis should be considered. He could return to his usual and customary job with a prophylactic work restriction of no work at or above shoulder level as well as no repetitive lifting at or above shoulder level.

On [redacted] he saw Dr. [redacted] for a QME in orthopedics. His report of his injuries, treatment, and subsequent symptoms was generally consistent with that provided on current exam. Dr. [redacted] diagnosed neck, spine, right wrist, left knee, and left shoulder injuries. Causation was industrial to the [redacted] injuries. The applicant was not yet MMI. Regarding the left shoulder, he recommended surgery. With regard to the left knee, he should be provided with additional treatment including possible physical therapy, cortisone injections and/or arthroscopic surgery. Regarding the right hand, he had symptomatic carpal tunnel syndrome, which might require carpal tunnel release. Regarding his spine pain, including the cervical, thoracic and lumbar spine, he should be treated symptomatically and with observance of therapeutic measures such as therapy and medication.

On [redacted] he saw Dr. [redacted] The applicant complained of right thumb, lumbar spine, left knee, and cervical spine pain with burning, numbness, and tingling. Dr. [redacted] diagnosed disc protrusion, cervical/lumbar spine and Carpal tunnel syndrome, right wrist. His carpal tunnel surgery was scheduled for [redacted] Dr. [redacted] prescribed Percocet 5/325 mg and Vistaril 50 mg. He was to remain off work until [redacted] approximately one year after the carpal tunnel surgery. Associated documents indicate that the applicant experienced benefit from the carpal tunnel surgery.

On [redacted] he saw Dr. [redacted], who diagnosed left shoulder/upper arm strain. There was also left shoulder strain with focal tear of the superior labrum. The applicant's report of his injuries, treatment, and symptoms was generally consistent with that provided on current exam. MR arthrogram was requested. The applicant was released to modified work with restrictions of no pushing and no use of the left arm above shoulder level.

On [redacted] he saw Dr. [redacted] for a urology QME due to sexual dysfunction, including premature ejaculation and difficulty with movement due to back pain. Dr [redacted] diagnosed Back pain; Erectile dysfunction; and Premature ejaculation. Dr. [redacted] opined that, with patients with back problems causing

erectile dysfunction, it was the pain that interfered with their ability to concentrate and maintain the erection. Premature ejaculation was always psychological. His erectile dysfunction was not work-related. No further workup or treatment of the erectile dysfunction on an industrial basis was indicated.

On [redacted] he saw Dr. [redacted] for a QME re-evaluation. Since the qualified medical evaluation of [redacted] the applicant was authorized for surgery, but his treating physician was removed from the network. He now complained of 2 additional problems. Because of his multiple pain symptoms, he used to be asleep in a prone position, but now he had to sleep on his back. With changes in his sleeping position, he was having sleep apnea and having difficulty with snoring. In addition, he was having some difficulty with sexual function. He was able to achieve an erection, but he could not bring his partner to climax because of his inability to perform due to multiple pain and limitations.

Dr. [redacted] diagnosed Status post mechanical fall off of an 8-foot ladder on [redacted] Chronic neck pain with multilevel cervical degenerative disk disease without disk herniation; Chronic thoracic sprain/strain with multilevel thoracic degenerative disk disease; Chronic lower back pain with 2 mm L5-S1 disk degeneration on MRI; Right carpal tunnel syndrome, mild, according to electromyography/nerve conduction studies with chronic persistent carpal tunnel symptoms; Left knee contusion with normal MRI on [redacted] with clinical evidence of persistent symptomatic plica; Asymptomatic plica of the right knee, un-injured; Separate injury with-the same employer on [redacted] with a left shoulder injury with MRI evidence of focal superior labral tear, tendinosis and Type II acromion with persistent impingement with a positive MRI finding of [redacted] Sleep disturbance; Possible sexual dysfunction. For the left shoulder, he was still a candidate for arthroscopic surgery with subacromial decompression and repair of the superior labral tear. He continued to remain temporarily partially disabled.

On [redacted] Dr. [redacted] issued a supplemental report. Dr. [redacted] disagreed with the non-certification by the IMR for the left shoulder. Dr. [redacted] insisted that the surgery be authorized. For the left knee, the applicant could also elect arthroscopic excision. For the right carpal tunnel syndrome, he might consider carpal tunnel release in the future. For the cervical, thoracic, and lumbar spine, he did not have much in the way of surgical pathology.

On [redacted] in the course of pre-operative clearance for carpal tunnel release, he was diagnosed with obstructive sleep apnea. He was diagnosed with depression and weight gain. On [redacted] he underwent the surgery.

On [redacted] he saw Dr. [redacted] and complained of constant pain. He felt like his shoulder was going to dislocate. The cortisone injection administered on his last visit helped for only 2 to 3 days. He was diagnosed with sprain/strain, left shoulder. He was to start physical therapy. He remained off work until [redacted] This is generally consistent with applicant report.

On [redacted] he saw Dr. [redacted] The applicant was currently taking Aleve or Advil. He was on temporary disability. There was no change in his neck pain and back symptoms. He had pain when sleeping. He complained of stiffness and soreness, and right wrist numbness. His right hand was also shaking and trembling. He was to start physical therapy. He was released to modified duty. The estimate for maximum medical improvement was 3 to 6 months. This is consistent with applicant report that Dr. Greenfield has not yet released him.

Discussion of Psychological Testing:

In the current evaluation, results of the applicant-reported Beck Depression and Anxiety Inventories indicate that the applicant reported moderate levels of symptoms of anxiety and moderate levels of symptoms of depression. Results of the clinician-reported Hamilton scales indicated that the applicant was experiencing mild symptoms of anxiety, and mild symptoms of depression.

The current MMPI-2 profile was valid for interpretation. The current MMPI-2 profile suggests that the applicant is experiencing somatic reactivity under stress as a primary difficulty. The client presents a picture of physical problems and a reduced level of psychological functioning. He may have periods of invalidism and dependency. His physical complaints may be vague, may have appeared suddenly after a period of stress, and may not be traceable to actual organic changes. He may be manifesting fatigue, vague pain, weakness, or unexplained periods of dizziness. It is noted that this profile is generally consistent with his report of difficulties with his physical symptoms, but he does not appear to show features of dependency, and his physical symptoms have been objectively corroborated.

The profile also suggests that he has seriously contemplated suicide, but he denied suicidal ideation on exam.

The diagnoses suggested by this profile include Conversion Disorder or Somatization Disorder. They might also receive an Axis II diagnosis of Dependent Personality. These diagnoses are inconsistent with my current diagnosis of Adjustment Disorder with Mixed Anxiety and Depression. It is noted that there is confirmation of his physical complaints by multiple providers. With regard to the suggested diagnosis of Dependent Personality, by the applicant's report, he maintains independence to the extent that he can, and also feels pressured as a Latino male to remain in a non-dependent role.

Discussion of Credibility of the Applicant:

The applicant has moderate to high credibility. His report was generally consistent with data in available records. He did not pan-endorse psychiatric symptoms. He attempted to recall details of his history. His MMPI-2 profile was valid for interpretation. He was open about non-industrial stressors. He goes to school and plans to transfer to a university to become a computer programmer. He takes part in household activities and self-care. He admitted to engaging in some recreational activities. These factors support his credibility.

However, the applicant's credibility is reduced slightly. There was a discrepancy between self-report and clinician-rated perceptions of his depression symptoms (mild vs. moderate). Moreover, though his MMPI-2 profile was valid, his profile was somewhat inconsistent with his self-report and presentation on exam. These factors slightly reduce his credibility.

I considered the applicant's credibility when arriving at my GAF finding of 62. This reflects overall mild symptoms, as reflected by the applicant's credible report of his symptoms and functioning.

Discussion of Diagnoses:

Based on review of the records, psychological testing, and mental status exam, the applicant meets DSM-IV-TR criteria for Adjustment Disorder with Mixed Anxiety and Depression, Chronic.

The applicant meets criteria for Adjustment Disorder with Mixed Anxiety and Depression, Chronic because he is experiencing emotional symptoms in response to identifiable events. His symptoms occurred within three months of these events. After this time, his emotional symptoms became in excess of what might normally

be expected and created significant marital, functional, and family impairment. Because these symptoms do not meet another specific Axis I disorder, are not part of another pre-existing disorder, and do not represent bereavement, the diagnosis of adjustment disorder is applicable. His symptoms of depression and anxiety include sadness, sexual dysfunction, marital dysfunction, sadness, sleep difficulties, worry, concentration difficulties due to pain, irritability, and rumination. It has been ongoing for longer than 6 months, and thus it is considered chronic.

Discussion of GAF Rating:

I have found a current GAF score of 62, which indicates that his symptom constellation is in the mild range. He reported current symptoms of depression, sexual dysfunction, marital dysfunction, sadness, sleep difficulties, worry, concentration difficulties due to pain, irritability, and rumination.

A lower GAF in the 51-60 range is not appropriate because his symptoms are mild, not moderate. He helps care for his autistic daughter and his other children. He is currently performing well as a part-time community college student, with plans for university transfer and a career in computer programming. He is independent with showering, grooming, feeding, toileting, and hygiene. He walks the dog. He goes on infrequent outings.

A higher GAF in the 71-80 range is not indicated because his symptoms are mild, not slight. He reported current symptoms of depression, sexual dysfunction, marital dysfunction, sadness, sleep difficulties, worry, concentration difficulties due to pain, irritability, and rumination. He does not have many leisure activities. He does not socialize much. He argues with his children. He does not have hobbies.

I considered his credibility when finding the current GAF. Although his self-report of symptoms on psychological measures differed slightly from my rating (mild vs. moderate), there was no evidence of exaggeration on the MMPI-2. Hence, the current GAF reflects mild overall symptomatology and functional deficits.

Discussion of Causation:

The applicant's Adjustment Disorder with Mixed Anxiety and Depression, Chronic was 100% caused by his 2010 musculoskeletal injury.

Though he suffered an additional injury in [redacted], his psychiatric symptoms had emerged prior to that time, as documented in the medical records. Moreover, though he was terminated, his psychiatric symptoms had emerged prior to that time.

Following careful psychiatric evaluation, I have determined that the events of the applicant's employment were the predominant cause of the mental disorder and need for treatment.

Section 3208.3(h) does not apply, as personnel actions did not cause his psychiatric injury. As explained above, he had already sustained his psychiatric injury prior to termination.

Section 3208.3(e) does not apply, as this is not a post-termination claim. He was terminated, but had filed a claim prior to his termination.

Discussion of Compensability of Psychiatric Injury:

The actual events of employment were predominant as to all other causes combined to have produced a psychiatric injury as described above. This disability meets requirements under section 3208.3 for predominant and substantial cause. Therefore it appears that his psychiatric injury is compensable.

Permanent and Stationary Status:

The applicant's psychiatric condition is not yet permanent and stationary. His physical condition is not permanent and stationary. Dr. [redacted] feels he should have surgery. Moreover, the applicant has not had any psychological or psychiatric treatment.

Given the lack of psychiatric treatment and a clear permanent and stationary finding for his primary medical condition, he is not yet permanent and stationary. He will not be psychiatrically permanent and stationary until he is orthopedically permanent and stationary and he has received at least four months of the recommended mental health treatment.

Future Treatment:

I recommend that the applicant have access to weekly psychotherapy visits with a supportive therapist. If his condition does not significant improve after four weeks

of psychotherapy, he should be referred to a psychiatrist for monthly visits for the prescription of anti-depressant, anti-anxiety, and sleep medications. He should have monthly psychiatric visits and weekly psychotherapy thereafter.

Periods of Disability:

The applicant has not had any periods of temporary total or partial disability on a purely psychiatric basis.

Apportionment:

Apportionment is deferred until such time that applicant's psychiatric condition is permanent and stationary.

I note potentially apportionable factors found on current exam that may be considered in apportionment analysis once the applicant is permanent and stationary. These include martial difficulties family difficulties related to religious differences between his and his wife's family, as well as discord with his mother-in-law regarding his right to raise his oldest non-biological daughter. His feeling of betrayal relative to his termination may also be grounds for apportionment.

Other Recommended Evaluations:

I do not recommend any other evaluations at this time.

OPINION ON INDUSTRIAL CAUSATION

Within reasonable medical probability, the actual events of employment were predominant (>50%) to all the causes combined to have produced a psychiatric injury. This injury meets requirements under section 3208.3 for predominant cause. **It is within reasonable medical probability that the applicant's Adjustment Disorder with Mixed Anxiety and Depression, Chronic was 100% caused by his [redacted] musculoskeletal injury.**

Though he suffered an additional injury in [redacted], his psychiatric symptoms had emerged prior to that time. Moreover, though he was terminated, his psychiatric symptoms had emerged prior to that time.

Following careful psychiatric evaluation, I have determined that the events of the applicant's employment were the predominant cause of the mental disorder and need for treatment.

Section 3208.3(h) does not apply, as personnel actions did not cause his psychiatric injury.

Section 3208.3(e) does not apply, as this is not a post-termination claim. He was terminated, but had filed a claim by 2011, prior to his termination.

It does not appear that section 3208.3(b)(2) applies, as this case is not a direct result of exposure to significant violent acts.

The injuries have arisen out of employment and during the course of employment.

Of course I defer the determination of causation regarding his orthopedic injuries to the appropriate medical specialists. Should an orthopedic specialist conclude that the applicant's orthopedic injuries are not industrial in nature, I may reconsider my findings.

TEMPORARY DISABILITY

The applicant has not had any periods of temporary total or partial disability on a purely psychiatric basis

PERMANENT AND STATIONARY

The applicant's psychiatric condition is not yet permanent and stationary. His physical condition is not permanent and stationary. Dr. [redacted] feels he should have surgery. Moreover, the applicant has not had any psychological or psychiatric treatment.

Given the lack of psychiatric treatment and a clear permanent and stationary finding for his primary medical condition, he is not yet permanent and stationary. He will not be psychiatrically permanent and stationary until he is orthopedically permanent and stationary and he has received at least four months of the recommended mental health treatment.

FACTORS OF DISABILITY

Factors of permanent disability are deferred until the applicant's psychiatric condition reaches permanent and stationary status.

PERMANENT DISABILITY

Permanent disability opinions are deferred until the applicant's psychiatric condition reaches permanent and stationary status.

NEED FOR FUTURE MEDICAL/PSYCHIATRIC TREATMENT

Medical treatment was reasonable and necessary to cure and relieve the effects of the injury in accordance with Labor Code Section 4604.5. The ACOEM Guidelines appeared to have been utilized by treating physicians and shall be presumed to be correct as to the issue, extent and scope of medical treatment involved. He has not reached maximum medical improvement, and additional treatment is necessary to reach maximum medical improvement as described above.

I recommend that the applicant have access to weekly psychotherapy visits with a supportive therapist. If his condition does not significant improve after four weeks of psychotherapy, he should be referred to a psychiatrist for monthly visits for the prescription of anti-depressant, anti-anxiety, and sleep medications. He should have monthly psychiatric visits and weekly psychotherapy thereafter.

VOCATIONAL REHABILITATION

Vocational rehabilitation is deferred until the applicant's psychiatric condition

reaches permanent and stationary status.

I defer to the appropriate orthopedic specialist in terms of to what extent his orthopedic injuries may require vocational rehabilitation or a modified position.

APPORTIONMENT ACCORDING TO SB 899 LC 4663

Apportionment is deferred until such time that applicant's psychiatric condition is permanent and stationary.

I note potentially apportionable factors found on current exam that may be considered in apportionment analysis once the applicant is permanent and stationary. These include martial difficulties family difficulties related to religious differences between his and his wife's family, as well as discord with his mother-in-law regarding his right to raise his oldest non-biological daughter. His feeling of betrayal relative to his termination may also be grounds for apportionment.

CONCLUSIONS

1) The patient is diagnosed with the following DSM-IV-TR disorder: Adjustment Disorder with Mixed Anxiety and Depression, chronic.
2) This disorder has arisen out of the course of employment. Employment at [redacted] is predominant as to all other causes combined to have produced the psychiatric injuries.
3) The applicant's Adjustment Disorder with Mixed Anxiety and Depression, Chronic was 100% caused by his industrial musculoskeletal injury.
4) The applicant is assigned a GAF of 62, corresponding to a WPI of 12.
5) He has not had any periods of temporary total or partial disability on a psychiatric basis.
6) The applicant is not yet permanent and stationary as he is not yet orthopedically permanent and stationary and has not received mental health treatment.
7) He requires further treatment in order to achieve maximal medical improvement. He should have four weeks of supportive psychotherapy, and then be referred for psychiatric evaluation if his symptoms do not appreciably improve. After that, he should have monthly psychotherapy and psychiatric visits.
8) Issues of permanent disability, factors of disability, vocational rehabilitation, and apportionment are deferred until the applicant has reached permanent and stationary status on a psychiatric basis.

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this examiner, including the applicant's direct anamnesis.

Thank you for the opportunity of serving as qualified medical examiner, in the specialty of Psychiatry, for this most interesting case and condition.

Sincerely,

[redacted]

Gabor Vari, M.D., QME
Diplomate, American Board of
Psychiatry and Neurology

Attachments: Appendix A Work Function Impairment Form, Appendix B Declaration.

APPENDIX A - WORK FUNCTION IMPAIRMENT FORM

	WORK FUNCTION	IMPAIRMENT	DATA
1.	**Ability to comprehend and follow instructions.** (A) Maintain attention and concentration for necessary periods; (B) Understand written and oral instructions; (C) Perform work requiring setting limits, tolerance and standards.	**Deferred**	History and Psychiatric Examination
2.	**Ability to perform simple and repetitive tasks.** (A) Ask simple questions or request assistance; (B) Perform activities of a routine nature; (C) Ability to remember locations and work procedures.	**Deferred**	History and Psychiatric Examination
3.	**Ability to maintain a work pace appropriate to a given workload.** (A) Perform activities within a schedule, maintain regular attendance and be punctual; (B) Complete normal work day and work at a constant pace.	**Deferred**	History and Psychiatric Examination
4.	**Ability to perform complex or varied tasks.** (A) Synthesize, coordinate and analyze data; (B) Perform tasks requiring precise attention of set limits, tolerance and standards.	**Deferred**	History and Psychiatric Examination
5.	**Ability to relate to other people beyond giving and receiving instructions.** (A) Get along with co-workers or peers; (B) Perform work activities requiring negotiating, explaining or persuading; (C) Respond appropriately to criticism.	**Deferred**	History and Psychiatric Examination
6.	**Ability to influence people.** (A) Ability to convince or direct others; (B) Understanding the meaning of words and use them effectively; (C) Interact appropriately with people.	**Deferred**	History and Psychiatric Examination
7.	**Ability to make generalizations, evaluations or decisions without immediate supervision.** (A) Recognize the potential hazards and follow precautions; (B) Understand and remember detailed instructions; (C) Make independent decisions or judgments; (D) Set realistic goals and make plans independent of others.	**Deferred**	History and Psychiatric Examination
8.	**Ability to accept and carry out responsibility for direction, control and planning.** (A) Set realistic goals or make plans independent of others; (B) Negotiate, instruct and supervise; (C) Respond appropriately to changes in work conditions.	**Deferred**	History and Psychiatric Examination

MINIMAL	=	causing discomfort, but not disabling
VERY SLIGHT	=	detectable impairment
SLIGHT	=	noticeable impairment
MODERATE	=	marked impairment
SEVERE	=	unable to perform work functions

APPENDIX B - <u>DECLARATION</u>

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

[redacted]

[redacted]

_____

Gabor Vari, M.D.
Diplomate, American Board of
Psychiatry and Neurology

December 23, 2022

TO: Each Trustee
Board of Retirement

FROM: Ricki Contreras, Manager
Disability Retirement Services Division

FOR: January 4, 2023, Board of Retirement Meeting

SUBJECT: **DISMISS WITH PREJUDICE THE APPEAL OF BARBARA C. YU**

Ms. Barbara C. Yu applied for a service-connected disability retirement on December 4, 2017. On September 12, 2019, the Board denied her application for service-connected disability retirement and granted her a non-service connected disability retirement with the option of an earlier effective date.

Ms. Yu's attorney filed a timely appeal. On November 18, 2022, he advised LACERA that his client did not wish to proceed with the appeal for a service-connected disability retirement.

IT IS THEREFORE RECOMMENDED THAT THE BOARD:

Dismiss with prejudice Barbara C. Yu's appeal for a service-connected disability retirement.

FJB: RC: mb

Yu, Barbara.docx

Attachment

NOTED AND REVIEWED:

Francis J. Boyd, Sr. Staff Counsel

Date: 12/23/2022

December 23, 2022

TO: Each Trustee
Board of Retirement

FROM: Ricki Contreras, Division Manager
Disability Retirement Services

SUBJECT: **APPEAL FOR THE BOARD OF RETIREMENT'S MEETING OF JANUARY 4, 2023**

IT IS RECOMMENDED that the Board of Retirement grant the appeal and request for administrative hearing received from the following applicant, and direct the Disability Retirement Services Manager to refer this case to a referee:

5272B	Frances M. Govens	In Pro Per	Deny SCD – Grant NSCD With Option of Earlier Effective Date, Employer Cannot Accommodate

RC:kw

LACERA

December 21, 2022

TO: Each Trustee,
Board of Retirement

FROM: Steven P. Rice SPR
Chief Counsel

FOR: January 4, 2023 Board of Retirement Meeting

SUBJECT: AB 2449 Teleconference Meeting Procedures

Recommendation

That the Board of Retirement discuss and provide input on the implementation process for the AB 2449 teleconference meeting procedures that may be used by staff in preparing a policy for consideration by the Board at a future meeting.

Legal Authority

The Board of Retirement has plenary authority and fiduciary responsibility over matters of fund administration and management, including the manner in which Board and Committee meetings are conducted, under Article XVI, Section 17 of the California Constitution and Government Code Sections 31520, 31520.1, and 31595 of the County Employees Retirement Act of 1937.

This item was originally presented to the Board's Operations Oversight Committee (OOC) at its meetings on December 7, 2022. Board and Committee members discussed that this matter, which relates to procedures for Board and Committee meetings, should be brought directly to the Board. The OOC therefore voted to refer the item to the full Board without a recommendation. A trustee also requested that the Board memo include discussion of accommodation for Trustees who reside more than two to three hours from the regular place of the meetings in Pasadena, California. The accommodation issue is the subject of a separate Board memo, but it is also included here insofar as it relates to teleconferencing under AB 2449.

Background on AB 2449

This memo discusses implementation options for the new teleconference meeting procedures under AB 2449, which was signed into the law by the Governor on September 13, 2022, effective January 1, 2023. A copy is attached.

The AB 2449 procedures are separate from the COVID emergency rules under AB 361 and Section 54953(e) that the Boards have utilized since September 2021, and which will remain in effect until January 1, 2024 and at that time are repealed. While AB 2449 is

effective on January 1, 2023, the AB 2449 rules will not be relevant or operative for LACERA's Boards and Committees until the March 2023 meetings and thereafter. This is because the Board of Retirement and Board of Investments approved at their September 23, 2022 joint meeting that the Boards and Committees will continue to use the COVID emergency rules until the State of Emergency ends, which is expected to occur on February 28, 2023.

The traditional teleconference rules requiring that each teleconference location be identified and open to the public will continue to be available under AB 2449.

AB 2449 creates three sets of new rules for teleconferencing under Section 54953, each of which applies for a different period of time.

- **Effective from January 1, 2023 through January 1, 2024.** Under this version of Section 54953(f)-(l), the following rules will apply:

    - A quorum of the legislative body must participate from the same physical location in the County of Los Angeles, for which the meeting is agendized. A quorum must be physically present for the entire meeting. This location must be open to the public. The meeting must be livestreamed, and there must be a two-way telephonic or audio-visual method of viewing and providing public comment.

      Applying this part of the statute for the Board of Retirement, its Committees, and joint Committees, AB 2449 imposes the following limits for quorum and teleconference attendance, subject to the individual attendance limits discussed below:

Body	Quorum in Person	Maximum by Teleconference
BOR	Five	Four (plus alternates if not needed for a quorum)
IBLC	Three	One (plus alternate if not needed for a quorum)
OOC	Three	One (plus alternate if not needed for a quorum)
JOGC	Five	Three
Audit	Four	Three

    - The remaining members of the body may participate remotely, without the need to agendize their location or open it to the public, if either:

- First, the member notifies the body at the earliest opportunity, including at the start of a regular meeting, of their need to appear remotely for just cause, including a general description of the circumstances supporting the just cause. "Just cause" is defined as (1) childcare or caregiving needs of certain family members or a domestic partner, (2) contagious illness that prevents attendance, (3) a need related to a physical or mental disability as defined in Government Code Sections 12926 and 12926.1 which is not accommodated, or (4) travel while on official public business of the body or another state or local agency. As stated above, a quorum must be physically present in person for the entire meeting; if an in-person quorum is lost, the body will not be able to take action. Even though notice of "just cause" can be made as late as the start of the meeting, the meeting cannot proceed if there is not an in-person quorum.

  The "just cause" excuse from in-person attendance cannot be invoked more than two meetings per calendar year; or

- Second, the member requests the legislative body to allow them to participate remotely due to emergency circumstances and the body takes action to approve the request. "Emergency circumstances" are defined as a physical or family medical emergency that prevents the member from attending in person. The body must request a general description of the circumstances of not more than twenty words and without disclosing personal medical information. The member making the request must make it as soon as possible. The body may act on the request as an urgency item by majority vote under Section 54952.2(b)(4), only if there is not sufficient time to place the request on the posted agenda. Separate requests must be made by a member each time they seek to request to participate remotely. An in-person quorum must be present for the entire meeting. A request cannot be acted upon in the absence of an in- person quorum.

- These provisions in total may not be used as a means for any members to participate in teleconference meetings for a period of more than three consecutive months or 20% of the regular meetings of the body within a calendar year or more than two meetings if the body regularly meets fewer than ten times per calendar year.

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Therefore, for the Board of Retirement, its Committees, and joint Committees, AB 2449 imposes the following limits on each Trustee's teleconference attendance at regular meetings per calendar year:

BOR	Maximum of two teleconference meetings/Trustee/year
IBLC	Maximum of two teleconference meetings/Trustee/year
OOC	Maximum of two teleconference meetings/Trustee/year
JOGC	Maximum of two teleconference meetings/Trustee/year
Audit	Maximum of two teleconference meetings/Trustee/year

- The member participating remotely must state whether any other individuals 18 years or older are present in the room at the remote location with the member and the general nature of the member's relationship with any such individuals.

- The body must have and implement a procedure for receiving and swiftly resolving request for reasonable accommodation from individuals with disabilities under the ADA. The ADA defines disability for purposes of accommodation as a physical or mental impairment that substantially limits one or more major life activities (sometimes referred to in the regulations as an "actual disability"), or a record of a physical or mental impairment that substantially limited a major life activity ("record of" disability). See 42 U.S.C. § 12102. The body shall conduct meetings under this section consistent with applicable civil rights and nondiscrimination laws.

  Therefore, in response to the trustee question about accommodation, if there is a disability that prevents a trustee from travelling to Pasadena on the morning of a regular meeting, LACERA's policy will need to provide for accommodation of that request. However, AB 2449 limits teleconference attendance to less than a quorum of the body, and therefore there may be circumstances where accommodation is not possible to meet the business needs of the body for an in-person quorum to meet legal requirements. As discussed below, LACERA's policy will need to include a reasonable process for resolving competing requests for teleconference attendance. Under the ADA, requests based on disability should take priority.

- The body may offer additional teleconference or physical locations from which the public may observe and address the body.

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- The COVID emergency teleconference rules under Section 54953(e) will still be in effect concurrently with the above rules through January 1, 2024.

- **Effective from January 1, 2024 to January 1, 2026.** Under this version of Section 54953(f)-(i), the same rules as described above apply, except this version will go into effect after the current COVID emergency provisions will no longer be in effect, having been repealed on January 1, 2024.

- **Effective from and after January 1, 2026.** Under this version of Section 54953, the above rules are repealed, and the Brown Act will return exclusively to the historical teleconference rules where teleconference locations must be agendized and open to the public.

Options for AB 2449 Implementation Procedures

The Board's AB 2449 policy must include provisions consistent with the requirements set forth above, which are not discretionary insofar as they relate to the in person quorum requirement and teleconferencing limits for each Trustee. The Executive Board Assistants will maintain records to ensure that all Trustees do not exceed the maximum permitted number of teleconference meeting attendance each calendar year. Forms will be created for trustees to use in making their request and presenting their general description of "just cause" or "emergency circumstances." A designated email address will be provided for submission of requests.

Since it may develop that there is a greater demand for teleconferencing positions at any given meeting than permitted by AB 2449 (i.e., requests by more than a quorum), it may be helpful to have a system of established priorities. Any system will need to be capable of implementation by staff or by the Board or Committee Chair because it is not possible under AB 2449 for the Board, or a Committee, to act in the absence of a quorum in person. Any system will also need to be separately implemented for each Board and Committee since each body has different quorum requirements and teleconference limits based on size and meeting frequency. Any system must be built to ensure ADA compliance, which is required by AB 2449, so as not to allow cause based on attendance at a conference or other business event to take priority over a health or disability necessity. Therefore, the statute implies that requests based on disability must receive priority.

The options listed below are possible solutions for resolving priorities if there is a greater demand for teleconferencing than allowed for any given Board or Committee meeting:

1. *Evaluate All Requests.* The Board may determine that each teleconference request will be considered and evaluated by staff. Under this option, action would be taken based on evaluation of the "general description" as required by AB 2449

that must be provided by each requesting Trustee. Decisions would be based on staff's evaluation of the merit of each request. This option has the disadvantage of placing staff in the difficult position of deciding the relative merit of individual requests.

2. *First Come, First Served.* Under this system, priority will be determined by the order in which Trustees advise staff in writing of their need for teleconference based on either just cause or emergency and provide the required "general description." This option has the advantage of being objective, without any need for staff discretion, but it suffers from the disadvantage of not considering the relative merit of requests.

3. *Chair Discretion.* This system assigns responsibility for weighing requests to the Chair of the Board and each Committee. This option reserves authority for each Board or Committee meeting to the Chair of the body, which is an existing Chair authority. The Board of Retirement Charter provides in Section 4.1 that the Chair shall "facilitate and preside over BOR meetings." The Board of Retirement Standing Committee Charters provide in Section E that, "Each Committee Chair will be responsible for setting meeting dates and agendas." This option also removes the responsibility from staff for administering the allocation of teleconference attendance.

4. *Prioritization Based on Trustee Seniority.* The Board may adopt a system of seniority lists like those maintained used for Board officer selection. Such lists would be constructed identically to the officer selection lists, but they would be created and maintained separately for the Board and each Committee. Like the "first come, first served" option, a list system is objective, but it does not consider the relative merits of requests. This system has the advantage of having already been debated by the Board and accepted in its implementation to date.

The Board may consider variations of these options or propose others.

Conclusion

Based on the above discussion, staff recommends that the Board of Retirement discuss and provide input on the implementation process for the AB 2449 teleconference meeting procedures that may be used by staff in preparing a policy for consideration by the Board at a future meeting.

Attachment

c: Santos H. Kreimann Jonathan Grabel Luis A. Lugo JJ Popowich
Laura Guglielmo Barry Lew

AB-2449 Open meetings: local agencies: teleconferences. (2021-2022)

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Date Published: 09/14/2022 09:00 PM

Assembly Bill No. 2449

CHAPTER 285

An act to amend, repeal, and add Sections 54953 and 54954.2 of the Government Code, relating to local government.

[Approved by Governor September 13, 2022. Filed with Secretary of State September 13, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2449, Blanca Rubio. Open meetings: local agencies: teleconferences.

Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act generally requires posting an agenda at least 72 hours before a regular meeting that contains a brief general description of each item of business to be transacted or discussed at the meeting, and prohibits any action or discussion from being undertaken on any item not appearing on the posted agenda. The act authorizes a legislative body to take action on items of business not appearing on the posted agenda under specified conditions. The act contains specified provisions regarding providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined.

Existing law, until January 1, 2024, authorizes a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health.

This bill would revise and recast those teleconferencing provisions and, until January 1, 2026, would authorize a local agency to use teleconferencing without complying with the teleconferencing requirements that each teleconference location be identified in the notice and agenda and that each teleconference location be accessible to the public if at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction. Under this exception, the bill would authorize a member to participate remotely under specified circumstances, including participating remotely for just cause or due to emergency circumstances. The emergency circumstances basis for remote participation would be contingent on a request to, and action by, the legislative body, as prescribed. The bill, until January 1, 2026, would authorize a legislative body to consider and

take action on a request from a member to participate in a meeting remotely due to emergency circumstances if the request does not allow sufficient time to place the proposed action on the posted agenda for the meeting for which the request is made. The bill would define terms for purposes of these teleconferencing provisions.

This bill would impose prescribed requirements for this exception relating to notice, agendas, the means and manner of access, and procedures for disruptions. The bill would require the legislative body to implement a procedure for receiving and swiftly resolving requests for reasonable accommodation for individuals with disabilities, consistent with federal law.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose.

This bill would make legislative findings to that effect.

Vote: majority Appropriation: no Fiscal Committee: no Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 54953 of the Government Code, as amended by Section 3 of Chapter 165 of the Statutes of 2021, is amended to read:

54953. (a) All meetings of the legislative body of a local agency shall be open and public, and all persons shall be permitted to attend any meeting of the legislative body of a local agency, except as otherwise provided in this chapter.

(b) (1) Notwithstanding any other provision of law, the legislative body of a local agency may use teleconferencing for the benefit of the public and the legislative body of a local agency in connection with any meeting or proceeding authorized by law. The teleconferenced meeting or proceeding shall comply with all otherwise applicable requirements of this chapter and all otherwise applicable provisions of law relating to a specific type of meeting or proceeding.

(2) Teleconferencing, as authorized by this section, may be used for all purposes in connection with any meeting within the subject matter jurisdiction of the legislative body. If the legislative body of a local agency elects to use teleconferencing, the legislative body of a local agency shall comply with all of the following:

(A) All votes taken during a teleconferenced meeting shall be by rollcall.

(B) The teleconferenced meetings shall be conducted in a manner that protects the statutory and constitutional rights of the parties or the public appearing before the legislative body of a local agency.

(C) The legislative body shall give notice of the meeting and post agendas as otherwise required by this chapter.

(D) The legislative body shall allow members of the public to access the meeting and the agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3.

(3) If the legislative body of a local agency elects to use teleconferencing, it shall post agendas at all teleconference locations. Each teleconference location shall be identified in the notice and agenda of the meeting or proceeding, and each teleconference location shall be accessible to the public. During the teleconference, at least a quorum of the members of the legislative body shall participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction, except as provided in subdivisions (d) and (e).

(c) (1) No legislative body shall take action by secret ballot, whether preliminary or final.

(2) The legislative body of a local agency shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(3) Prior to taking final action, the legislative body shall orally report a summary of a recommendation for a final action on the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive, as defined in subdivision (d) of Section 3511.1, during the open meeting in which the final action is to be taken. This paragraph shall not affect the public's right under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1) to inspect or copy records created or received in the process of developing the recommendation.

(d) (1) Notwithstanding the provisions relating to a quorum in paragraph (3) of subdivision (b), if a health authority conducts a teleconference meeting, members who are outside the jurisdiction of the authority may be counted toward the establishment of a quorum when participating in the teleconference if at least 50 percent of the number of members that would establish a quorum are present within the boundaries of the territory over which the authority exercises jurisdiction, and the health authority provides a teleconference number, and associated access codes, if any, that allows any person to call in to participate in the meeting and the number and access codes are identified in the notice and agenda of the meeting.

(2) Nothing in this subdivision shall be construed as discouraging health authority members from regularly meeting at a common physical site within the jurisdiction of the authority or from using teleconference locations within or near the jurisdiction of the authority. A teleconference meeting for which a quorum is established pursuant to this subdivision shall be subject to all other requirements of this section.

(3) For purposes of this subdivision, a health authority means any entity created pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.9605 of the Welfare and Institutions Code, any joint powers authority created pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 for the purpose of contracting pursuant to Section 14087.3 of the Welfare and Institutions Code, and any advisory committee to a county-sponsored health plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code if the advisory committee has 12 or more members.

(e) (1) The legislative body of a local agency may use teleconferencing without complying with the requirements of paragraph (3) of subdivision (b) if the legislative body complies with the requirements of paragraph (2) of this subdivision in any of the following circumstances:

(A) The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing.

(B) The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(C) The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote, pursuant to subparagraph (B), that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(2) A legislative body that holds a meeting pursuant to this subdivision shall do all of the following:

(A) In each instance in which notice of the time of the teleconferenced meeting is otherwise given or the agenda for the meeting is otherwise posted, the legislative body shall also give notice of the means by which members of the public may access the meeting and offer public comment. The agenda shall identify and include an opportunity for all persons to attend via a call-in option or an internet-based service option.

(B) In the event of a disruption that prevents the legislative body from broadcasting the meeting to members of the public using the call-in option or internet-based service option, or in the event of a disruption within the local agency's control that prevents members of the public from offering public comments using the call-in option or internet-based service option, the legislative body shall take no further action on items appearing on the meeting agenda until public access to the meeting via the call-in option or internet-based service option is restored. Actions taken on agenda items during a disruption that prevents the legislative body from broadcasting the meeting may be challenged pursuant to Section 54960.1.

(C) The legislative body shall not require public comments to be submitted in advance of the meeting and must provide an opportunity for the public to address the legislative body and offer comment in real time.

(D) Notwithstanding Section 54953.3, an individual desiring to provide public comment through the use of an internet website, or other online platform, not under the control of the local legislative body, that requires registration to log in to a teleconference may be required to register as required by the third-party internet website or online platform to participate.

(E) (i) A legislative body that provides a timed public comment period for each agenda item shall not close the public comment period for the agenda item, or the opportunity to register, pursuant to subparagraph (F), to provide public comment until that timed public comment period has elapsed.

(ii) A legislative body that does not provide a timed public comment period, but takes public comment separately on each agenda item, shall allow a reasonable amount of time per agenda item to allow public members the opportunity to provide public comment, including time for members of the public to register pursuant to subparagraph (F), or otherwise be recognized for the purpose of providing public comment.

(iii) A legislative body that provides a timed general public comment period that does not correspond to a specific agenda item shall not close the public comment period or the opportunity to register, pursuant to subparagraph (F), until the timed general public comment period has elapsed.

(3) If a state of emergency remains active, or state or local officials have imposed or recommended measures to promote social distancing, in order to continue to teleconference without compliance with paragraph (3) of subdivision (b), the legislative body shall, not later than 30 days after teleconferencing for the first time pursuant to subparagraph (A), (B), or (C) of paragraph (1), and every 30 days thereafter, make the following findings by majority vote:

(A) The legislative body has reconsidered the circumstances of the state of emergency.

(B) Any of the following circumstances exist:

(i) The state of emergency continues to directly impact the ability of the members to meet safely in person.

(ii) State or local officials continue to impose or recommend measures to promote social distancing.

(4) This subdivision shall not be construed to require the legislative body to provide a physical location from which the public may attend or comment.

(f) (1) The legislative body of a local agency may use teleconferencing without complying with paragraph (3) of subdivision (b) if, during the teleconference meeting, at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda, which location shall be open to the public and situated within the boundaries of the territory over which the local agency exercises jurisdiction and the legislative body complies with all of the following:

(A) The legislative body shall provide at least one of the following as a means by which the public may remotely hear and visually observe the meeting, and remotely address the legislative body:

(i) A two-way audiovisual platform.

(ii) A two-way telephonic service and a live webcasting of the meeting.

(B) In each instance in which notice of the time of the teleconferenced meeting is otherwise given or the agenda for the meeting is otherwise posted, the legislative body shall also give notice of the means by which members of the public may access the meeting and offer public comment.

(C) The agenda shall identify and include an opportunity for all persons to attend and address the legislative body directly pursuant to Section 54954.3 via a call-in option, via an internet-based service option, and at the in-person location of the meeting.

(D) In the event of a disruption that prevents the legislative body from broadcasting the meeting to members of the public using the call-in option or internet-based service option, or in the event of a disruption within the local agency's control that prevents members of the public from offering public comments using the call-in option or internet-based service option, the legislative body shall take no further action on items appearing on the meeting agenda until public access to the meeting via the call-in option or internet-based service option is restored. Actions taken on agenda items during a disruption that prevents the legislative body from broadcasting the meeting may be challenged pursuant to Section 54960.1.

(E) The legislative body shall not require public comments to be submitted in advance of the meeting and must provide an opportunity for the public to address the legislative body and offer comment in real time.

(F) Notwithstanding Section 54953.3, an individual desiring to provide public comment through the use of an internet website, or other online platform, not under the control of the local legislative body, that requires registration to log in to a teleconference may be required to register as required by the third-party internet website or online platform to participate.

(2) A member of the legislative body shall only participate in the meeting remotely pursuant to this subdivision, if all of the following requirements are met:

(A) One of the following circumstances applies:

(i) The member notifies the legislative body at the earliest opportunity possible, including at the start of a regular meeting, of their need to participate remotely for just cause, including a general description of the circumstances relating to their need to appear remotely at the given meeting. The provisions of this clause shall not be used by any member of the legislative body for more than two meetings per calendar year.

(ii) The member requests the legislative body to allow them to participate in the meeting remotely due to emergency circumstances and the legislative body takes action to approve the request. The legislative body shall request a general description of the circumstances relating to their need to appear remotely at the given meeting. A general description of an item generally need not exceed 20 words and shall not require the member to disclose any medical diagnosis or disability, or any personal medical information that is already exempt under existing law, such as the Confidentiality of Medical Information Act (Chapter 1 (commencing with Section 56) of Part 2.6 of Division 1 of the Civil Code). For the purposes of this clause, the following requirements apply:

(I) A member shall make a request to participate remotely at a meeting pursuant to this clause as soon as possible. The member shall make a separate request for each meeting in which they seek to participate remotely.

(II) The legislative body may take action on a request to participate remotely at the earliest opportunity. If the request does not allow sufficient time to place proposed action on such a request on the posted agenda for the meeting for which the request is made, the legislative body may take action at the beginning of the meeting in accordance with paragraph (4) of subdivision (b) of Section 54954.2.

(B) The member shall publicly disclose at the meeting before any action is taken, whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.

(C) The member shall participate through both audio and visual technology.

(3) The provisions of this subdivision shall not serve as a means for any member of a legislative body to participate in meetings of the legislative body solely by teleconference from a remote location for a period of more than three consecutive months or 20 percent of the regular meetings for the local agency within a calendar year, or more than two meetings if the legislative body regularly meets fewer than 10 times per calendar year.

(g) The legislative body shall have and implement a procedure for receiving and swiftly resolving requests for reasonable accommodation for individuals with disabilities, consistent with the federal Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), and resolving any doubt in favor of accessibility. In each instance in which notice of the time of the meeting is otherwise given or the agenda for the meeting is otherwise posted, the legislative body shall also give notice of the procedure for receiving and resolving requests for accommodation.

(h) The legislative body shall conduct meetings subject to this chapter consistent with applicable civil rights and nondiscrimination laws.

(i) (1) Nothing in this section shall prohibit a legislative body from providing the public with additional teleconference locations.

(2) Nothing in this section shall prohibit a legislative body from providing members of the public with additional physical locations in which the public may observe and address the legislative body by electronic means.

(j) For the purposes of this section, the following definitions shall apply:

(1) "Emergency circumstances" means a physical or family medical emergency that prevents a member from attending in person.

(2) "Just cause" means any of the following:

(A) A childcare or caregiving need of a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner that requires them to participate remotely. "Child," "parent," "grandparent," "grandchild," and "sibling" have the same meaning as those terms do in Section 12945.2.

(B) A contagious illness that prevents a member from attending in person.

(C) A need related to a physical or mental disability as defined in Sections 12926 and 12926.1 not otherwise accommodated by subdivision (g).

(D) Travel while on official business of the legislative body or another state or local agency.

(3) "Remote location" means a location from which a member of a legislative body participates in a meeting pursuant to subdivision (f), other than any physical meeting location designated in the notice of the meeting. Remote locations need not be accessible to the public.

(4) "Remote participation" means participation in a meeting by teleconference at a location other than any physical meeting location designated in the notice of the meeting. Watching or listening to a meeting via webcasting or another similar electronic medium that does not permit members to interactively hear, discuss, or deliberate on matters, does not constitute remote participation.

(5) "State of emergency" means a state of emergency proclaimed pursuant to Section 8625 of the California Emergency Services Act (Article 1 (commencing with Section 8550) of Chapter 7 of Division 1 of Title 2).

(6) "Teleconference" means a meeting of a legislative body, the members of which are in different locations, connected by electronic means, through either audio or video, or both.

(7) "Two-way audiovisual platform" means an online platform that provides participants with the ability to participate in a meeting via both an interactive video conference and a two-way telephonic function.

(8) "Two-way telephonic service" means a telephone service that does not require internet access, is not provided as part of a two-way audiovisual platform, and allows participants to dial a telephone number to listen and verbally participate.

(9) "Webcasting" means a streaming video broadcast online or on television, using streaming media technology to distribute a single content source to many simultaneous listeners and viewers.

(k) This section shall remain in effect only until January 1, 2024, and as of that date is repealed.

SEC. 2. Section 54953 of the Government Code, as added by Section 4 of Chapter 165 of the Statutes of 2021, is amended to read:

54953. (a) All meetings of the legislative body of a local agency shall be open and public, and all persons shall be permitted to attend any meeting of the legislative body of a local agency, except as otherwise provided in this chapter.

(b) (1) Notwithstanding any other provision of law, the legislative body of a local agency may use teleconferencing for the benefit of the public and the legislative body of a local agency in connection with any meeting or proceeding authorized by law. The teleconferenced meeting or proceeding shall comply with all otherwise applicable requirements of this chapter and all otherwise applicable provisions of law relating to a specific type of meeting or proceeding.

(2) Teleconferencing, as authorized by this section, may be used for all purposes in connection with any meeting within the subject matter jurisdiction of the legislative body. If the legislative body of a local agency elects to use teleconferencing, the legislative body of a local agency shall comply with all of the following:

(A) All votes taken during a teleconferenced meeting shall be by rollcall.

(B) The teleconferenced meetings shall be conducted in a manner that protects the statutory and constitutional rights of the parties or the public appearing before the legislative body of a local agency.

(C) The legislative body shall give notice of the meeting and post agendas as otherwise required by this chapter.

(D) The legislative body shall allow members of the public to access the meeting and the agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3.

(3) If the legislative body of a local agency elects to use teleconferencing, it shall post agendas at all teleconference locations. Each teleconference location shall be identified in the notice and agenda of the meeting or proceeding, and each teleconference location shall be accessible to the public. During the teleconference, at least a quorum of the members of the legislative body shall participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction, except as provided in subdivision (d).

(c) (1) No legislative body shall take action by secret ballot, whether preliminary or final.

(2) The legislative body of a local agency shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(3) Prior to taking final action, the legislative body shall orally report a summary of a recommendation for a final action on the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive, as defined in subdivision (d) of Section 3511.1, during the open meeting in which the final action is to be taken. This paragraph shall not affect the public's right under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1) to inspect or copy records created or received in the process of developing the recommendation.

(d) (1) Notwithstanding the provisions relating to a quorum in paragraph (3) of subdivision (b), if a health authority conducts a teleconference meeting, members who are outside the jurisdiction of the authority may be counted toward the establishment of a quorum when participating in the teleconference if at least 50 percent of the number of members that would establish a quorum are present within the boundaries of the territory over which the authority exercises jurisdiction, and the health authority provides a teleconference number, and associated access codes, if any, that allows any person to call in to participate in the meeting and the number and access codes are identified in the notice and agenda of the meeting.

(2) Nothing in this subdivision shall be construed as discouraging health authority members from regularly meeting at a common physical site within the jurisdiction of the authority or from using teleconference locations within or near the jurisdiction of the authority. A teleconference meeting for which a quorum is established pursuant to this subdivision shall be subject to all other requirements of this section.

(3) For purposes of this subdivision, a health authority means any entity created pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.9605 of the Welfare and Institutions Code, any joint powers authority created pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 for the purpose of contracting pursuant to Section 14087.3 of the Welfare and Institutions Code, and any advisory committee to a county-sponsored health plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code if the advisory committee has 12 or more members.

(e) (1) The legislative body of a local agency may use teleconferencing without complying with paragraph (3) of subdivision (b) if, during the teleconference meeting, at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda, which location shall be open to the public and situated within the boundaries of the territory over which the local agency exercises jurisdiction and the legislative body complies with all of the following:

(A) The legislative body shall provide at least one of the following as a means by which the public may remotely hear and visually observe the meeting, and remotely address the legislative body:

(i) A two-way audiovisual platform.

(ii) A two-way telephonic service and a live webcasting of the meeting.

(B) In each instance in which notice of the time of the teleconferenced meeting is otherwise given or the agenda for the meeting is otherwise posted, the legislative body shall also give notice of the means by

which members of the public may access the meeting and offer public comment.

(C) The agenda shall identify and include an opportunity for all persons to attend and address the legislative body directly pursuant to Section 54954.3 via a call-in option, via an internet-based service option, and at the in-person location of the meeting.

(D) In the event of a disruption that prevents the legislative body from broadcasting the meeting to members of the public using the call-in option or internet-based service option, or in the event of a disruption within the local agency's control that prevents members of the public from offering public comments using the call-in option or internet-based service option, the legislative body shall take no further action on items appearing on the meeting agenda until public access to the meeting via the call-in option or internet-based service option is restored. Actions taken on agenda items during a disruption that prevents the legislative body from broadcasting the meeting may be challenged pursuant to Section 54960.1.

(E) The legislative body shall not require public comments to be submitted in advance of the meeting and must provide an opportunity for the public to address the legislative body and offer comment in real time.

(F) Notwithstanding Section 54953.3, an individual desiring to provide public comment through the use of an internet website, or other online platform, not under the control of the local legislative body, that requires registration to log in to a teleconference may be required to register as required by the third-party internet website or online platform to participate.

(2) A member of the legislative body shall only participate in the meeting remotely pursuant to this subdivision, if all of the following requirements are met:

(A) One of the following circumstances applies:

(i) The member notifies the legislative body at the earliest opportunity possible, including at the start of a regular meeting, of their need to participate remotely for just cause, including a general description of the circumstances relating to their need to appear remotely at the given meeting. The provisions of this clause shall not be used by any member of the legislative body for more than two meetings per calendar year.

(ii) The member requests the legislative body to allow them to participate in the meeting remotely due to emergency circumstances and the legislative body takes action to approve the request. The legislative body shall request a general description of the circumstances relating to their need to appear remotely at the given meeting. A general description of an item generally need not exceed 20 words and shall not require the member to disclose any medical diagnosis or disability, or any personal medical information that is already exempt under existing law, such as the Confidentiality of Medical Information Act (Chapter 1 (commencing with Section 56) of Part 2.6 of Division 1 of the Civil Code). For the purposes of this clause, the following requirements apply:

(I) A member shall make a request to participate remotely at a meeting pursuant to this clause as soon as possible. The member shall make a separate request for each meeting in which they seek to participate remotely.

(II) The legislative body may take action on a request to participate remotely at the earliest opportunity. If the request does not allow sufficient time to place proposed action on such a request on the posted agenda for the meeting for which the request is made, the legislative body may take action at the beginning of the meeting in accordance with paragraph (4) of subdivision (b) of Section 54954.2.

(B) The member shall publicly disclose at the meeting before any action is taken whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.

(C) The member shall participate through both audio and visual technology.

(3) The provisions of this subdivision shall not serve as a means for any member of a legislative body to participate in meetings of the legislative body solely by teleconference from a remote location for a period of more than three consecutive months or 20 percent of the regular meetings for the local agency within a calendar year, or more than two meetings if the legislative body regularly meets fewer than 10 times per calendar year.

(f) The legislative body shall have and implement a procedure for receiving and swiftly resolving requests for reasonable accommodation for individuals with disabilities, consistent with the federal Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), and resolving any doubt in favor of accessibility. In each instance in which notice of the time of the meeting is otherwise given or the agenda for the meeting is otherwise posted, the legislative body shall also give notice of the procedure for receiving and resolving requests for accommodation.

(g) The legislative body shall conduct meetings subject to this chapter consistent with applicable civil rights and nondiscrimination laws.

(h) (1) Nothing in this section shall prohibit a legislative body from providing the public with additional teleconference locations.

(2) Nothing in this section shall prohibit a legislative body from providing members of the public with additional physical locations in which the public may observe and address the legislative body by electronic means.

(i) For the purposes of this section, the following definitions shall apply:

(1) "Emergency circumstances" means a physical or family medical emergency that prevents a member from attending in person.

(2) "Just cause" means any of the following:

(A) A childcare or caregiving need of a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner that requires them to participate remotely. "Child," "parent," "grandparent," "grandchild," and "sibling" have the same meaning as those terms do in Section 12945.2.

(B) A contagious illness that prevents a member from attending in person.

(C) A need related to a physical or mental disability as defined in Sections 12926 and 12926.1 not otherwise accommodated by subdivision (f).

(D) Travel while on official business of the legislative body or another state or local agency.

(3) "Remote location" means a location from which a member of a legislative body participates in a meeting pursuant to subdivision (e), other than any physical meeting location designated in the notice of the meeting. Remote locations need not be accessible to the public.

(4) "Remote participation" means participation in a meeting by teleconference at a location other than any physical meeting location designated in the notice of the meeting. Watching or listening to a meeting via webcasting or another similar electronic medium that does not permit members to interactively hear, discuss, or deliberate on matters, does not constitute remote participation.

(5) "Teleconference" means a meeting of a legislative body, the members of which are in different locations, connected by electronic means, through either audio or video, or both.

(6) "Two-way audiovisual platform" means an online platform that provides participants with the ability to participate in a meeting via both an interactive video conference and a two-way telephonic function.

(7) "Two-way telephonic service" means a telephone service that does not require internet access, is not provided as part of a two-way audiovisual platform, and allows participants to dial a telephone number to listen and verbally participate.

(8) "Webcasting" means a streaming video broadcast online or on television, using streaming media technology to distribute a single content source to many simultaneous listeners and viewers.

(j) This section shall become operative January 1, 2024, shall remain in effect only until January 1, 2026, and as of that date is repealed.

SEC. 3. Section 54953 is added to the Government Code, to read:

54953. (a) All meetings of the legislative body of a local agency shall be open and public, and all persons shall be permitted to attend any meeting of the legislative body of a local agency, except as otherwise provided in this chapter.

(b) (1) Notwithstanding any other provision of law, the legislative body of a local agency may use teleconferencing for the benefit of the public and the legislative body of a local agency in connection with any meeting or proceeding authorized by law. The teleconferenced meeting or proceeding shall comply with all requirements of this chapter and all otherwise applicable provisions of law relating to a specific type of meeting or proceeding.

(2) Teleconferencing, as authorized by this section, may be used for all purposes in connection with any meeting within the subject matter jurisdiction of the legislative body. All votes taken during a teleconferenced meeting shall be by rollcall.

(3) If the legislative body of a local agency elects to use teleconferencing, it shall post agendas at all teleconference locations and conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties or the public appearing before the legislative body of a local agency. Each teleconference location shall be identified in the notice and agenda of the meeting or proceeding, and each teleconference location shall be accessible to the public. During the teleconference, at least a quorum of the members of the legislative body shall participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction, except as provided in subdivision (d). The agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3 at each teleconference location.

(4) For the purposes of this section, "teleconference" means a meeting of a legislative body, the members of which are in different locations, connected by electronic means, through either audio or video, or both. Nothing in this section shall prohibit a local agency from providing the public with additional teleconference locations.

(c) (1) No legislative body shall take action by secret ballot, whether preliminary or final.

(2) The legislative body of a local agency shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(3) Prior to taking final action, the legislative body shall orally report a summary of a recommendation for a final action on the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive, as defined in subdivision (d) of Section 3511.1, during the open meeting in which the final action is to be taken. This paragraph shall not affect the public's right under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1) to inspect or copy records created or received in the process of developing the recommendation.

(d) (1) Notwithstanding the provisions relating to a quorum in paragraph (3) of subdivision (b), if a health authority conducts a teleconference meeting, members who are outside the jurisdiction of the authority may be counted toward the establishment of a quorum when participating in the teleconference if at least 50 percent of the number of members that would establish a quorum are present within the boundaries of the territory over which the authority exercises jurisdiction, and the health authority provides a teleconference number, and associated access codes, if any, that allows any person to call in to participate in the meeting and the number and access codes are identified in the notice and agenda of the meeting.

(2) Nothing in this subdivision shall be construed as discouraging health authority members from regularly meeting at a common physical site within the jurisdiction of the authority or from using teleconference locations within or near the jurisdiction of the authority. A teleconference meeting for which a quorum is established pursuant to this subdivision shall be subject to all other requirements of this section.

(3) For purposes of this subdivision, a health authority means any entity created pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.9605 of the Welfare and Institutions Code, any joint powers authority created pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 for the purpose of contracting pursuant to Section 14087.3 of the Welfare and Institutions Code, and any advisory committee to a county-sponsored health plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code if the advisory committee has 12 or more members.

(e) This section shall become operative January 1, 2026.

SEC. 4. Section 54954.2 of the Government Code is amended to read:

54954.2. (a) (1) At least 72 hours before a regular meeting, the legislative body of the local agency, or its designee, shall post an agenda containing a brief general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of an item

generally need not exceed 20 words. The agenda shall specify the time and location of the regular meeting and shall be posted in a location that is freely accessible to members of the public and on the local agency's Internet Web site, if the local agency has one. If requested, the agenda shall be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), and the federal rules and regulations adopted in implementation thereof. The agenda shall include information regarding how, to whom, and when a request for disability-related modification or accommodation, including auxiliary aids or services, may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting.

(2) For a meeting occurring on and after January 1, 2019, of a legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state that has an Internet Web site, the following provisions shall apply:

(A) An online posting of an agenda shall be posted on the primary Internet Web site homepage of a city, county, city and county, special district, school district, or political subdivision established by the state that is accessible through a prominent, direct link to the current agenda. The direct link to the agenda shall not be in a contextual menu; however, a link in addition to the direct link to the agenda may be accessible through a contextual menu.

(B) An online posting of an agenda including, but not limited to, an agenda posted in an integrated agenda management platform, shall be posted in an open format that meets all of the following requirements:

(i) Retrievable, downloadable, indexable, and electronically searchable by commonly used Internet search applications.

(ii) Platform independent and machine readable.

(iii) Available to the public free of charge and without any restriction that would impede the reuse or redistribution of the agenda.

(C) A legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state that has an Internet Web site and an integrated agenda management platform shall not be required to comply with subparagraph (A) if all of the following are met:

(i) A direct link to the integrated agenda management platform shall be posted on the primary Internet Web site homepage of a city, county, city and county, special district, school district, or political subdivision established by the state. The direct link to the integrated agenda management platform shall not be in a contextual menu. When a person clicks on the direct link to the integrated agenda management platform, the direct link shall take the person directly to an Internet Web site with the agendas of the legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state.

(ii) The integrated agenda management platform may contain the prior agendas of a legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state for all meetings occurring on or after January 1, 2019.

(iii) The current agenda of the legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state shall be the first agenda available at the top of the integrated agenda management platform.

(iv) All agendas posted in the integrated agenda management platform shall comply with the requirements in clauses (i), (ii), and (iii) of subparagraph (B).

(D) For the purposes of this paragraph, both of the following definitions shall apply:

(i) "Integrated agenda management platform" means an Internet Web site of a city, county, city and county, special district, school district, or political subdivision established by the state dedicated to providing the entirety of the agenda information for the legislative body of the city, county, city and county, special district, school district, or political subdivision established by the state to the public.

(ii) "Legislative body" has the same meaning as that term is used in subdivision (a) of Section 54952.

(E) The provisions of this paragraph shall not apply to a political subdivision of a local agency that was established by the legislative body of the city, county, city and county, special district, school district, or

political subdivision established by the state.

(3) No action or discussion shall be undertaken on any item not appearing on the posted agenda, except that members of a legislative body or its staff may briefly respond to statements made or questions posed by persons exercising their public testimony rights under Section 54954.3. In addition, on their own initiative or in response to questions posed by the public, a member of a legislative body or its staff may ask a question for clarification, make a brief announcement, or make a brief report on his or her own activities. Furthermore, a member of a legislative body, or the body itself, subject to rules or procedures of the legislative body, may provide a reference to staff or other resources for factual information, request staff to report back to the body at a subsequent meeting concerning any matter, or take action to direct staff to place a matter of business on a future agenda.

(b) Notwithstanding subdivision (a), the legislative body may take action on items of business not appearing on the posted agenda under any of the conditions stated below. Prior to discussing any item pursuant to this subdivision, the legislative body shall publicly identify the item.

(1) Upon a determination by a majority vote of the legislative body that an emergency situation exists, as defined in Section 54956.5.

(2) Upon a determination by a two-thirds vote of the members of the legislative body present at the meeting, or, if less than two-thirds of the members are present, a unanimous vote of those members present, that there is a need to take immediate action and that the need for action came to the attention of the local agency subsequent to the agenda being posted as specified in subdivision (a).

(3) The item was posted pursuant to subdivision (a) for a prior meeting of the legislative body occurring not more than five calendar days prior to the date action is taken on the item, and at the prior meeting the item was continued to the meeting at which action is being taken.

(4) To consider action on a request from a member to participate in a meeting remotely due to emergency circumstances, pursuant to Section 54953, if the request does not allow sufficient time to place the proposed action on the posted agenda for the meeting for which the request is made. The legislative body may approve such a request by a majority vote of the legislative body.

(c) This section is necessary to implement and reasonably within the scope of paragraph (1) of subdivision (b) of Section 3 of Article I of the California Constitution.

(d) For purposes of subdivision (a), the requirement that the agenda be posted on the local agency's Internet Web site, if the local agency has one, shall only apply to a legislative body that meets either of the following standards:

(1) A legislative body as that term is defined by subdivision (a) of Section 54952.

(2) A legislative body as that term is defined by subdivision (b) of Section 54952, if the members of the legislative body are compensated for their appearance, and if one or more of the members of the legislative body are also members of a legislative body as that term is defined by subdivision (a) of Section 54952.

(e) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

SEC. 5. Section 54954.2 is added to the Government Code, to read:

54954.2. (a) (1) At least 72 hours before a regular meeting, the legislative body of the local agency, or its designee, shall post an agenda containing a brief general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of an item generally need not exceed 20 words. The agenda shall specify the time and location of the regular meeting and shall be posted in a location that is freely accessible to members of the public and on the local agency's Internet Web site, if the local agency has one. If requested, the agenda shall be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), and the federal rules and regulations adopted in implementation thereof. The agenda shall include information regarding how, to whom, and when a request for disability-related modification or accommodation, including auxiliary aids or services, may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting.

(2) For a meeting occurring on and after January 1, 2019, of a legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state that has an Internet Web site, the following provisions shall apply:

(A) An online posting of an agenda shall be posted on the primary Internet Web site homepage of a city, county, city and county, special district, school district, or political subdivision established by the state that is accessible through a prominent, direct link to the current agenda. The direct link to the agenda shall not be in a contextual menu; however, a link in addition to the direct link to the agenda may be accessible through a contextual menu.

(B) An online posting of an agenda including, but not limited to, an agenda posted in an integrated agenda management platform, shall be posted in an open format that meets all of the following requirements:

(i) Retrievable, downloadable, indexable, and electronically searchable by commonly used Internet search applications.

(ii) Platform independent and machine readable.

(iii) Available to the public free of charge and without any restriction that would impede the reuse or redistribution of the agenda.

(C) A legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state that has an Internet Web site and an integrated agenda management platform shall not be required to comply with subparagraph (A) if all of the following are met:

(i) A direct link to the integrated agenda management platform shall be posted on the primary Internet Web site homepage of a city, county, city and county, special district, school district, or political subdivision established by the state. The direct link to the integrated agenda management platform shall not be in a contextual menu. When a person clicks on the direct link to the integrated agenda management platform, the direct link shall take the person directly to an Internet Web site with the agendas of the legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state.

(ii) The integrated agenda management platform may contain the prior agendas of a legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state for all meetings occurring on or after January 1, 2019.

(iii) The current agenda of the legislative body of a city, county, city and county, special district, school district, or political subdivision established by the state shall be the first agenda available at the top of the integrated agenda management platform.

(iv) All agendas posted in the integrated agenda management platform shall comply with the requirements in clauses (i), (ii), and (iii) of subparagraph (B).

(D) For the purposes of this paragraph, both of the following definitions shall apply:

(i) "Integrated agenda management platform" means an Internet Web site of a city, county, city and county, special district, school district, or political subdivision established by the state dedicated to providing the entirety of the agenda information for the legislative body of the city, county, city and county, special district, school district, or political subdivision established by the state to the public.

(ii) "Legislative body" has the same meaning as that term is used in subdivision (a) of Section 54952.

(E) The provisions of this paragraph shall not apply to a political subdivision of a local agency that was established by the legislative body of the city, county, city and county, special district, school district, or political subdivision established by the state.

(3) No action or discussion shall be undertaken on any item not appearing on the posted agenda, except that members of a legislative body or its staff may briefly respond to statements made or questions posed by persons exercising their public testimony rights under Section 54954.3. In addition, on their own initiative or in response to questions posed by the public, a member of a legislative body or its staff may ask a question for clarification, make a brief announcement, or make a brief report on his or her own activities. Furthermore, a member of a legislative body, or the body itself, subject to rules or procedures of the legislative body, may provide a reference to staff or other resources for factual information, request staff to report back to the body

at a subsequent meeting concerning any matter, or take action to direct staff to place a matter of business on a future agenda.

(b) Notwithstanding subdivision (a), the legislative body may take action on items of business not appearing on the posted agenda under any of the conditions stated below. Prior to discussing any item pursuant to this subdivision, the legislative body shall publicly identify the item.

(1) Upon a determination by a majority vote of the legislative body that an emergency situation exists, as defined in Section 54956.5.

(2) Upon a determination by a two-thirds vote of the members of the legislative body present at the meeting, or, if less than two-thirds of the members are present, a unanimous vote of those members present, that there is a need to take immediate action and that the need for action came to the attention of the local agency subsequent to the agenda being posted as specified in subdivision (a).

(3) The item was posted pursuant to subdivision (a) for a prior meeting of the legislative body occurring not more than five calendar days prior to the date action is taken on the item, and at the prior meeting the item was continued to the meeting at which action is being taken.

(c) This section is necessary to implement and reasonably within the scope of paragraph (1) of subdivision (b) of Section 3 of Article I of the California Constitution.

(d) For purposes of subdivision (a), the requirement that the agenda be posted on the local agency's Internet Web site, if the local agency has one, shall only apply to a legislative body that meets either of the following standards:

(1) A legislative body as that term is defined by subdivision (a) of Section 54952.

(2) A legislative body as that term is defined by subdivision (b) of Section 54952, if the members of the legislative body are compensated for their appearance, and if one or more of the members of the legislative body are also members of a legislative body as that term is defined by subdivision (a) of Section 54952.

(e) This section shall become operative January 1, 2026.

SEC. 6. The Legislature finds and declares that Sections 1 and 2 of this act, which amend Section 54953 of the Government Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

By removing the requirement for agendas to be placed at the location of each public official participating in a public meeting remotely, including from the member's private home or hospital room, this act protects the personal, private information of public officials and their families while preserving the public's right to access information concerning the conduct of the people's business.

SEC. 7. The Legislature finds and declares that Sections 1 and 2 of this act, which amend Section 54953 of the Government Code, further, within the meaning of paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution, the purposes of that constitutional section as it relates to the right of public access to the meetings of local public bodies or the writings of local public officials and local agencies. Pursuant to paragraph (7) of subdivision (b) of Section 3 of Article I of the California Constitution, the Legislature makes the following findings:

This act is necessary to ensure minimum standards for public participation and notice requirements allowing for greater public participation in teleconference meetings.

LACERA

December 20, 2022

TO: Each Trustee,
Board of Retirement
Board of Investments

FROM: Santos H. Kreimann SHK
Chief Executive Officer

FOR: January 4, 2023 Board of Retirement Meeting
January 11, 2023 Board of Investments Meeting

SUBJECT: Reimbursement of Trustee Accommodation Expenses for Board and Committee Meetings in Pasadena, California

Recommendation

That the Board of Retirement and Board of Investments consider and clarify whether the Travel Policy should allow for reimbursement of hotel accommodation expenses for travel to scheduled Board or Committee meetings for Trustees who reside more than two hours or 50 miles, or some other time and distance, as directed by the Board, from the regular place of the meetings in Pasadena, California.

Legal Authority

The Boards have plenary authority and exclusive fiduciary responsibility for the administration of LACERA in the paramount interest of providing benefits to members and their beneficiaries. Cal. Const., art. XVI, § 17; Cal. Gov't Code § 31595. Establishment of standards for reimbursements to Trustees for reasonable and necessary costs of serving in their office is within the Boards' legal authority.

Discussion

A question has been raised as to whether or not the Boards have authority to grant reimbursement to Trustees for one night of hotel accommodation expenses if they live more than two hours from the place of the meeting on the grounds that it imposes difficulty and may reduce effectiveness for Trustees to participate in early morning meetings and maintain a quorum due to long travel times from their homes to the meeting location in Pasadena. The Chief Executive Officer has consulted with the Legal Office and fiduciary counsel in connection with this issue. Counsel have advised that this is a matter of policy that the Boards should specifically consider and determine.

LACERA's Trustee Travel Policy does not explicitly address attendance at regular Board and Committee meetings, or the costs of such attendance, and it has not been invoked in the past to cover such meeting expenses. While the general definition of "Administrative Meetings" in Section 1 of the LACERA Policy (p. 1) could reasonably be interpreted to include on-site LACERA Board and Committee meetings, the more specific recitation of conditions precedent to approval of reimbursements for Administrative Meetings in Section IV of the LACERA Policy (p. 7) is not explicitly read to include such regular on-site meetings. The policy states, in pertinent part, "The relevant Board will be informed of Trustee's need to attend Administrative Meetings and provide advance approval of the cost on such terms as deemed appropriate," which does not clearly apply to LACERA Board and Committee meetings.

However, the Travel Policy provides the CEO and Board Chair with the power to "authorize deviations of less than $1,000 per trip from the expense limits in this policy and subject to subsequent review of all expenses under this policy" (pp. 4-5). The policy also provides that either Board may, upon good cause presented in writing, "waive compliance with specific requirements of this policy when in the best interest of LACERA" (p. 8). Under these provisions, the CEO, Board Chairs, and the Boards themselves have the ability to approve policy deviations, including reimbursement of expenses for Board and Committee meetings in Pasadena. Counsel advised the CEO that it would be most prudent to bring this issue to the Boards for action rather than exercising his discretion given that the wording and intent of the policy does not clearly include Board and Committee meetings in the definition of "Administrative Meetings."

There is precedent for reimbursing Trustees for certain meeting expenses. LACERA reimburses all Trustees for mileage to meetings in Pasadena. LACERA also reimburses Trustees for travel expenses, including accommodations, incurred as the result of annual off-site Board meetings.

Regarding governance and Board trustee, elected Trustees and the ex officio members are not required by the County Employees Retirement Law of 1937 to live within Los Angeles County and therefore may reside outside the County. This is in contrast to the appointed Trustees who are required to be "electors" of L.A. County and thus be residents within the County. Cal. Gov't Code §§ 31520.1, 31520.2. Los Angeles County is large, however, and therefore even appointed trustees may live and work a substantial distance from LACERA's headquarters.

If a Trustee has a disability that prevents travel the day of the meeting, the Americans with Disabilities Act (ADA) may support reimbursement for accommodations necessary to travel the day before to ensure access to Board and Committee meetings as a governmental function of a local agency. The ADA defines disability for purposes of

accommodation as a physical or mental impairment that substantially limits one or more major life activities (sometimes referred to in the regulations as an "actual disability"), or a record of a physical or mental impairment that substantially limited a major life activity ("record of" disability). See 42 U.S.C. § 12102.

Consequently, based on the above factors, the Boards may consider these various factors in determining whether reimbursement should be provided for the cost of such travel by Trustees.

If a policy were adopted to reimburse accommodations for Pasadena meetings, it would be appropriate to consider limitations, such as (1) providing that it is only available to trustees who meet a time and distance standard, such as more than two or three hours from Pasadena, or 50 miles, or some other criteria, and (2) limiting reimbursable expenses to one night of accommodations at an approved rate and mileage, and discuss whether payment should be made for meals since meals would be paid personally by Trustees regardless of where they live.

Conclusion

Based on this information, it is recommended that the Board of Retirement and Board of Investments consider whether to allow reimbursement of hotel accommodation expenses for travel to scheduled Board or Committee meeting for Trustees who reside more than two to three hours, or 50 miles, or some other time and distance, from the regular place of the meetings in Pasadena, California.

Attachment

cc: Jonathan Grabel
Luis A. Lugo
Steven P. Rice
JJ Popowich
Laura Guglielmo
Carly Ntoya

ATTACHMENT

TRUSTEE TRAVEL POLICY

LACERA Board of Retirement & Board of Investments

Adopted May 11, 2022

TRUSTEE TRAVEL POLICY

I. PURPOSE

The purpose of this policy is to align travel by Trustees in connection with educational conferences and administrative meetings on LACERA's behalf with the Mission, Vision, Values, and work culture of the organization. The Board of Retirement and Board of Investments recognize that travel associated with education and administrative meetings on LACERA's behalf is a component of building the knowledge base and operational understanding of Trustees given their fiduciary responsibilities and will equip them to discharge their fiduciary duties for the sole benefit of active members, retirees, and their beneficiaries. To ensure incurring and paying travel expenses are allowed for only those expenses deemed reasonable and necessary for the proper administration of the system, the policy will be administered in a manner that can be overseen by the Boards and understood by LACERA members and other stakeholders as reasonable, cost effective, value-driven, and necessary to fulfill LACERA's Mission to Produce, Protect, and Provide the Promised Benefits.

This policy applies to travel in connection with Educational Conferences and Administrative Meetings. "Educational Conferences" are those conferences, seminars, and meetings that have an educational purpose. "Administrative Meetings" are meetings attended by Trustees in their LACERA capacity and further LACERA's interests, including legislative advocacy, speaking engagements, including a domestic and international Educational Conference at which a Trustee gives a speech, positions in the administration of pension related organizations, and similar events. This policy applies to LACERA Trustees only.

II. PRINCIPLES

The following principles shall govern Trustee travel in connection with Educational Conferences and Administrative Meetings on LACERA's behalf and the interpretation of this policy.

A. Performance of Fiduciary Duty. Travel for educational conferences and administrative meetings in furtherance of LACERA's interests is necessary and should be encouraged and undertaken in order that Trustees may obtain and share knowledge relevant to the proper performance of their fiduciary duty under the California Constitution, the County Employees Retirement Law of 1937 (CERL), and other applicable laws by a reasonable method and at reasonable cost for the value received. Specifically:

1. Duty of Loyalty. Education and travel must assist the Trustees to perform their fiduciary duty of loyalty to "discharge their duties with respect to the system solely in the interest of, and for the exclusive purposes of providing benefits to, participants and their beneficiaries, minimizing employer contributions thereto, and defraying reasonable expenses of administering the system. A retirement board's duty to its participants and their beneficiaries shall take precedence over any other duty." Cal. Const., art. XVI, § 17(b); *see* Cal. Gov't Code § 31595(a).

2. Duty of Prudence. Education and travel must assist the Trustees to perform their fiduciary duty of prudence to "discharge their duties with respect to the system with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with these matters would use in the conduct of an enterprise with a like character and like aims." Const., art. XVI, § 17(c); *see* Cal. Gov't Code § 31595(b).

B. *Focus on Mission.* Trustees have a fiduciary duty to make policy decisions consistent with applicable law, including constraints imposed by the Fund's budget. At the same time, travel may be necessary to support and enhance LACERA's Mission to Produce, Protect and Provide the Promised Benefits on behalf of LACERA members.

Trustees are expected to be and believed to be mindful and financially prudent in all travel and trip-related expenditures that consume resources funded by LACERA members.

i. All monies held in the Fund by LACERA are ultimately due and payable in the form of pension benefits to active and retired members. Therefore, all administrative, operational and travel expenditures should be able to withstand the scrutiny of our members, stakeholders, plan sponsors and the public at large, thereby minimizing any reputational risk to LACERA.
ii. Trustees are accountable for their actions and responsible for appropriate use of organizational resources and establishing policy creating limits and constraining expenditures. Travel policies for staff can be more restrictive depending on circumstances and financial constraints.

C. *Transparency.* Travel administrative procedures and guidelines are established and carried out in a manner that is easy for members and all other stakeholders to identify actions taken by Trustees.

i. Expenses incurred for travel and trips are clearly identifiable as business-related expenses only, not for personal expenses of the Trustee or any traveling companions.
ii. Travel expenses and trip information are reported to LACERA members and stakeholders via a public forum.
iii. Trustees recognize and accept their accountability and responsibility to LACERA members for travel and trip expenditures which are charged to LACERA.
iv. All Trustees electronically acknowledge and sign a travel attestation document (Appendix B) provided by staff annually on a calendar year basis, confirming their commitment to act responsibly and prudently and in the best interest of LACERA members.

D. *Simplicity, Uniformity and Consistency.* Travel administrative procedures and guidelines for claiming and reimbursing expenses are designed to be simple, uniform, and consistent, and should not be overly onerous so as to negatively affect Trustees.

i. Travel procedures should be a guide with simple, unambiguous rules for making and approving travel arrangements, and for the timely processing and accounting of trip related expenditures and reimbursements.
ii. Travel expenditures are documented on expense claims that are clear and concise.
iii. Travel expense reimbursement processes should be clear, consistent, transparent, convenient, efficient, and compliant with the Trustee Travel Policy.
iv. Travel expense methods are simple and universally applied so the reimbursement claim process is streamlined (e.g., all meals are claimed under the Per Diem Method).
v. Travel procedures, including administrative expense guidelines and reimbursement process, are maintained under the direction of the Chief Executive Officer (CEO) or their designee.

E. Ease of Execution. Travel administrative procedures and guidelines are established with administrative ease and designed to reduce the manual processes and the considerable effort required of staff. Processes related to travel reimbursements and processing expense claims should not be cumbersome and complicated for staff and Trustees.

i. Travel accommodations and Trustee conveniences are streamlined and provide a group of appropriate choices instead a vast menu of options.
ii. The process itself of conducting travel bookings and expense processing are considered a priority.
iii. Expense categories, reimbursement process, and claim forms are periodically reviewed and updated by staff.
iv. Trustees, not proxies, are responsible for obtaining, gathering, and submitting the appropriate documentation justifying expenditures in a timely manner.
v. External providers including travel agents and other travel-related industry services are to be considered and integrated into the process for Trustees and administrative ease.
vi. Technological tools for capturing and recording trip documentation are employed where reasonable and necessary considering cost implications.
vii. Practices will periodically be reviewed to ensure best practices and industry norms are included within the Trustee Travel Policy.

III. TRUSTEE TRAVEL

A. Approval. All travel requires approval of that Trustee's Board, except that Educational Conferences and Administrative Meetings in California where the total cost of attendance is no more than $3,000 are pre-approved for attendance and reimbursement, provided that a Trustee may not incur over $15,000 for all expenses of attending all such Educational Conferences and Administrative Meetings in a fiscal year without Board approval.

B. Cease Travel and Other Expenses. Trustees may consider whether and when to cease arranging future travel and expenses for Educational

Conferences and Administrative Meetings once they become aware their term of service will end. In considering this issue, Trustees may consider the following factors: For appointed Trustees, awareness may occur in the final year of their appointment and after the Board of Supervisors votes on the next appointment, or when an appointed Trustee has been told they will not be reappointed. For elected Trustees, awareness may occur when an elected Trustee decides not to run for reelection or when, as a candidate, is replaced once election results are certified by the Board of Supervisors. For the Ex-Officio Trustee, this occurs once a retirement is announced.

C. ***Authorized Expenses.*** Authorized travel expenses shall be determined by the Boards as set forth in Appendix A. LACERA shall use reasonable efforts to promptly reimburse trustees in accordance with this policy and Appendix A.

D. ***Costs of Administration.*** Travel expenses for Trustees shall be administrative costs of the Fund and may not be paid through third party contracts. It is LACERA's policy that Trustees shall not accept gifts of travel. Gifts of travel, including transportation, lodging, and meals, may be reportable as gifts to individual Trustees if not paid by LACERA.

E. ***Claims for Reimbursement.***

i. Submission. A travel expense reimbursement shall be claimed by completing an expense voucher form available from the Executive Board Assistants and submitting it to the appropriate authorizing person. Trustees may submit their expense reimbursements to their respective Executive Board Assistant. All expense reimbursement requests shall be accompanied by receipts and/or other reasonable documentation. Expense reimbursement records are subject to disclosure under the Public Records Act, with redaction of confidential information, such as personal addresses, telephone numbers, and credit card information. The deadline for submitting an education and travel reimbursement claim is 90 days after completing the education, or 30 days after the fiscal year-end, whichever comes first. Extensions to this deadline may be granted by the Board Chair.

ii. Approval. The Executive Board Assistants will receive and review, for compliance with this policy, all expense reimbursement requests prior to submission. The Financial and Accounting Services Division (FASD) will review expense reimbursement requests for compliance with this policy and shall only process and use reasonable efforts to promptly pay those that are in compliance and approved by the CEO or their designee. FASD will notify the CEO or their designee of all deficiencies in a submission by a Trustee, and the CEO or their designee will in turn notify the respective Trustee. LACERA will not reimburse a Trustee for expenses that are not authorized under this policy unless specifically exempted and approved by that Trustee's Board, except that, without Board approval, each Board Chair or the Chief Executive Officer may authorize deviations of less than $1,000

per trip from the expense limits in this policy and subject to subsequent review of all expenses for compliance with this policy.

F. Cancelation of Travel Arrangements.

i. Responsibility for Timely Cancelation. Trustees are responsible for timely canceling travel arrangements made on behalf of the Trustee which will not be used so that no costs will be incurred by LACERA.

ii. Responsibility for Costs Resulting from Untimely Cancelation. Trustees are responsible for all costs LACERA incurs as a result of the Trustee's failure to cancel travel arrangements before cancelation charges accrue, unless the failure to cancel was due to facts or circumstances beyond the Trustee's control. The Trustee must reimburse LACERA within 30 days after notification of the amount due. Notice will be provided by the Chief Executive Officer. If reimbursement is not made within such 30-day period, and payment is still due, the amount shall be deducted from any payment due the Trustee from LACERA. If a Trustee is enrolled for an Educational Conference or Administrative Meeting but fails to attend or timely cancel and LACERA incurs an expense as a result (e.g., conference registration, travel and lodging cancelation fees), that conference or meeting counts toward the limit under Section IV.C.2. of the Trustee Education Policy until the Trustee reimburses LACERA for all expenses incurred or cancelation is excused under Section III. F. iii. of this Trustee Travel Policy.

iii. Approval of Cancelation Costs with Good Cause. If the Trustee believes the failure to cancel was due to facts or circumstances beyond their control, they must submit written justification to the Board Chair within 30 days after receiving notification of the cancelation expenses due. For Trustees, the Board Chair will approve or disapprove the excuse in writing to the Trustee, with a copy to the Executive Board Assistant. If the individual is a Board Chair, then the written excuse must be submitted to that Board's Vice Chair who will then approve or disapprove the excuse. If the individual is a Vice Chair simultaneously serving as the acting Chair, then the Vice Chair's written excuse must be submitted to that Board's Secretary who will then approve or disapprove the excuse. Should a Trustee disagree with the Board Officer's determination, the Trustee may request the Executive Board Assistant to agendize the matter for consideration by the full Board.

G. Cash Advances. Hotel and airfare shall be purchased in advance by the Executive Board Assistants, and no cash advances will be allowed for such expenses. Cash advances for permitted per diem expenses in accordance with this policy may be allowed by the Chief Executive Officer for good cause. Trustees will account for any per diem cash advance on their trip expense report upon completion of the travel.

H. Expenses for Traveling Companions. Travel expenses for family members and/or traveling companions are not reimbursable by LACERA.

I. Additional Travel Days to Minimize Overall Travel Cost. Travel resulting in arrival one day prior to and/or one day after an Educational Conference or Administrative Meeting will be reimbursed if reasonably necessary because of time constraints. Travel resulting in arrival two days prior to and/or one day after international travel will be reimbursed as reasonably necessary based on the location of the Educational Conference or Administrative Meeting. In addition, lodging and per diem for extra days prior to or after an Educational Conference or Administrative Meeting will be reimbursed if such extension results in lower overall trip costs. If a Trustee adds personal travel before or after a trip, the extra personal days outside of the above restrictions shall not be reimbursed. Written justification for travel expenses incurred prior to or after an Educational Conference or Administrative Meeting shall be submitted with the claim for reimbursement.

J. Ground Transportation. Trustees will be expected to use taxis or ride sharing services to and from domestic destinations. Limousine or executive car services shall not be used in domestic locations unless the cost for such services is comparable to that of taxi services and/or airport parking; they may be used without restriction in international locations. Reimbursement of rental vehicles require justification and prior approval from the Chief Executive Officer. When renting a vehicle, purchase of optional insurance is not necessary as LACERA's insurance will cover the same risks.

K. International Travel Insurance. LACERA will purchase travel insurance covering Trustees while traveling internationally on LACERA business. The insurance will include accident, medical, security assistance and evacuation, travel assistance, trip cancelation, interruption or delay, and baggage loss or delay coverage.

L. Travel Reports.

i. Monthly. A monthly Travel Report shall be submitted to both Boards listing the current fiscal year's completed, anticipated, and canceled Education Conferences and Administrative Meetings (including whether excused under Section III. F. iii) for all Trustees on both Boards.

ii. Quarterly. A quarterly Travel Report shall be submitted to both Boards listing education and administrative travel expenses paid/reimbursed by LACERA for all Trustee on both Boards. Such report shall identify whether each item of travel was for an Educational Conference or Administrative Meeting, the purpose, location, cost by expense category, and whether excused under Section III. F. iii.

iii. Availability. The monthly and quarterly reports shall be agendized as reports for the Boards in the first month after they are available (and for privacy and personal security reasons, after travel has been completed) and shall be posted on lacera.com.

IV. ADMINISTRATIVE MEETINGS

The relevant Board will be informed of a Trustee's need to attend Administrative Meetings and provide advance approval of the cost on such terms as deemed appropriate.

V. BROWN ACT COMPLIANCE

Attendance at external Education Conferences and Administrative Meetings by more than four Trustees of a Board is not a violation of this provision, provided that the Trustees may not discuss any item of LACERA business.

VI. GIFTS AND CONFLICTS

The Boards desire to avoid even the appearance of impropriety in connection with education, and related expenses. The Boards acknowledge that acceptance of gifts of education and related expenses, such as registration, transportation, meals, and lodging by a public agency, though permitted under certain circumstances by applicable law, can create the appearance that LACERA encourages "pay to play" and may, unwittingly, create opportunities for undue influence on Trustees. This policy therefore does not permit LACERA as an entity to accept gifts of education, and related expenses. This policy does not prohibit certain payments for education and/or related expenses as part of the negotiated consideration under agreements with vendors, consultants, and managers, although all such payments should be reviewed in advance with the Legal Division to ensure compliance with applicable law, regulations, and reporting.

Items provided during Educational Conferences and Administrative Meetings may constitute reportable gifts.

Trustees should be familiar with the provisions of LACERA's Code of Ethical Conduct as it may apply to certain education and administrative meeting interaction with and items received from the sponsors or other attendees.

The Boards acknowledge that international travel, though expensive, is increasingly necessary in light of today's global economy and LACERA's ongoing prudent investment of a substantial portion of its assets outside the United States.

VII. EDUCATION POLICY AND PROCEDURES

This policy is subject to and will be read and interpreted in conjunction with the Trustee Education Policy.

VIII. POLICY PROVISIONS AND APPLICABLE LAW

A. Waiver of Policy Provisions. For good cause presented in writing, and in the exercise of its sound discretion, the Board of Retirement or the Board of Investments may waive compliance with specific requirements of this policy when in the best interest of LACERA.

B. Applicable Law. This policy is to be implemented in compliance with the relevant provisions of the California Government Code and other applicable law, and in harmony with existing philosophy, objectives, policies and guidelines previously approved by the Board of Retirement and the Board of Investments.

IX. SUSTAINABILITY

Trustees are encouraged to consider sustainability in making education and travel choices, including whether and how to travel, the viability and efficacy of alternative forms of participation (such as geographically closer or virtual meetings), the impact of business class vs. coach, the number of trips taken, and the number of Trustees participating in a single event, avoidance of car transportation when possible, and obtaining an estimate of the carbon footprint of travel and lodging options through available online tools and inclusion of estimates in board recommendation memos.

X. REVIEW

This policy shall be reviewed by the Joint Organizational Governance Committee, the Board of Retirement, and the Board of Investments every three years or as needed and may be amended by both Boards at such time.

Policy History: Restated and Approved by the Board of Retirement and Board of Investments on December 16, 2020 and updated and approved by the Board of Retirement and Board of Investments on May 5, 2022 and May 11, 2022, respectively. Prior versions are superseded and of no effect as of the stated approval date.

APPENDIX A
REIMBURSEMENT SCHEDULE

Amounts which can be reimbursed for transportation, lodging, meals, and other covered items are indicated as follows:

I. TRANSPORTATION:

A. Airline Travel

1. Trustees will travel in coach/economy class except that they may travel in business class or its equivalent for:

    a. Flights having (i) a scheduled non-stop flight time or total connecting travel time from original departing airport to the final destination airport of five hours or more, or (ii) a scheduled non-stop roundtrip flight time or total connecting roundtrip travel time of ten hours or more.

    b. Red-eye flights. "Red-eye flights" are defined as flights in which a majority of the flight time occurs between 10:00 PM and 6:00 AM.

    c. Flights arriving or departing at an international location, including Canada and Mexico.

2. LACERA will reimburse the additional cost of coach/economy class seats advertised as having additional leg room regardless of flight time.

3. Air travel will only be reimbursed at the lowest available non-refundable fare at the time of purchase (for class travel authorized under this Policy). Trustee may elect to fly on United, American, Delta, JetBlue, or Southwest Airlines for the dates and times of travel. Other carriers are authorized, but reimbursement shall not exceed the lowest non-refundable fare offered either amongst the five major airlines carriers mentioned above or three other major carriers who fly to selected destination.

4. Recognizing air carriers have begun charging for incidental items historically included in the ticket price (for example, checking luggage, providing pillows, blankets, and non-alcoholic beverages during flights, etc.), LACERA also will reimburse carrier charges for such incidental items upon submission of an itemized receipt. Alcoholic beverages will not be reimbursed.

5. Substantiation of airline travel shall include a copy of the ticket or E-mail confirmation showing the cost of the air travel.

6. Trustees traveling by air to conduct LACERA business may use only regularly scheduled airline services operating by an air carrier certified by the Federal

APPENDIX A
REIMBURSEMENT SCHEDULE

Aviation Administration or comparable foreign authority. Trustees are prohibited from traveling on LACERA business via private aircraft, including but not limited to aircraft owned, leased, or rented by the individual Trustee. Persons traveling on LACERA business via private aircraft will be deemed to be acting outside the scope of their responsibilities and employment. They will not be covered by LACERA's liability insurance. Trustees may not use travel points to pay for LACERA travel. Any points earned on LACERA's credit card will be used at the Chief Executive Officer's discretion.

B. Other Common Carrier Travel

1. Travel permitted under this policy should be accomplished in the most cost-effective and efficient manner practicable, considering the costs of the mode of transportation, travel time, accommodations, and per diem.

2. Generally, air travel is the most cost-effective and efficient means for long distance travel, with "long distance travel" defined as a travel to a site more than 300 miles from LACERA's headquarters.

3. Where a traveler has special travel needs or concerns such that travel by air for long distance travel is not practicable, then the traveler may use an alternate common carrier (e.g., train or bus) and incur such reasonable expenses associated with that mode of travel (e.g., sleeper car, additional days of per diem).

4. Substantiation of other common carrier travel shall include a copy of the ticket or E-mail confirmation showing the cost of the travel.

II. LODGING:

A. Room Cost

Reimbursement is limited to a standard class single room rate, including mandatory taxes and hotel fees. Actual expenses for lodging will be reimbursed upon submittal of receipts. For example, room upgrades, and bed and breakfast additions will be at the expense of the Trustee, unless for good cause such as the unavailability of standard rooms and/or international destinations.

B. Government Rates

Trustees traveling on LACERA business should always request government rates when making reservations and/or checking in. LACERA recognizes that the governmental rate offered for local governmental entities like LACERA may be higher

APPENDIX A
REIMBURSEMENT SCHEDULE

than the federal government rate, or may not be available at all, especially in connection with international travel.

C. Attendance at Educational Conferences and Administrative Meetings.

LACERA acknowledges that the cost of a standard room at an event hotel may exceed the standard lodging reimbursement rate. Nevertheless, Trustees attending events may stay at the designated hotel to promote convenient access, networking, and safety. Reimbursement for lodging at an event is limited to the standard room rate charged by the event hotel unless for good cause such as the unavailability of standard rooms and/or international destinations. When lodging at the event hotel is unavailable, reimbursement is limited to the best available rate for a standard room at a nearby hotel of comparable quality. The Trustee will be responsible for any excess cost.

D. Travel Not Connected with An Established Hotel Venue

The maximum lodging amounts are intended to cover the cost of lodging at adequate, suitable and moderately-priced facilities located near the destination city's airport or the specific area in the destination city where LACERA's business will be conducted without association with an established hotel venue. Reimbursement for lodging connected with such travel is limited to:

1. Domestic: Not more than three times the regular per diem rate for the location as established from time to time by the U.S. General Services Administration, found at www.gsa.gov (click on "per diem rates").

2. International: Not more than three times the rate for the location as established from time to time by the United States Department of State, found at: www.state.gov/m/a/als/prdm.

III. MEALS:

It is the policy's intent for the Trustee to be reimbursed for meals not pre-paid for by LACERA. As such, LACERA will not reimburse the Trustee for a meal which has been pre-paid for by LACERA (e.g., when conference registration includes meals), whether or not the Trustee consumed the meal, except where the Trustee could not consume the pre-paid meal because:

1. The Trustee has special dietary or medical concerns, or

2. It was reasonably necessary for the Trustee to conduct LACERA business while the pre-paid meal was being served.

APPENDIX A
REIMBURSEMENT SCHEDULE

Written justification as to which of the above two exceptions applies will be provided with the reimbursement request. However, written justification for any dietary restrictions or medical concerns need only be provided once annually by the Trustee.

Likewise, LACERA will not reimburse the Trustee for a meal paid for by a third party unless approved by the Chief Executive Officer.

Meal Reimbursement

Reimbursement for meals shall be based on the "Per Diem Method" only as defined below.

A. The Per Diem Method

1. Under the Per Diem Method, the Trustee agrees to accept a flat rate for meals. Trustees are not required to submit receipts.

2. The per diem allowance will be computed using the Meals & Incidental Expenses rate (the "M&IE Rate") published by the Internal Revenue Service and in effect on the date of travel for the locality of travel.

3. The per diem allowance shall be claimed in accordance with the Meals & Incidental Expenses Breakdown ("M&IE Breakdown") per the IRS, based on the M&IE Rate. The portion of the per diem the Trustee receives depends upon when the travel occurs. For example, if the travel occurs during normal breakfast and lunch times, the Trustee receives the per diem for breakfast and lunch; if the travel occurs during normal lunch and dinner times, the Trustee receives the per diem for lunch and dinner, etc.

IV. PORTERAGE:

Porterage may not be claimed using the Per Diem Method, as the Per Diem Method's IRS tables already factor in porterage reimbursement.

V. PARKING:

Parking, including airport parking, will be reimbursed at actual rate (receipt required).

VI. MILEAGE:

Use of a personal vehicle will be reimbursed on a per mile basis at the rate approved by the Internal Revenue Service as of the date of travel.

APPENDIX A
REIMBURSEMENT SCHEDULE

VII. OTHER BUSINESS EXPENSES:

Other covered business expenses reasonably incurred in connection with LACERA business, such as registration fees, business and personal telephone, fax, internet access, gym access (including the standard gym fee charged by the Trustee's hotel or, if hotel gym access is not available, the reasonable cost of daily access to a local gym or health facility), dry cleaning, and similar business expenses, shall be reimbursed upon submittal of receipts. Required vaccinations and required tests (such as PCR rapid tests for COVID-19) to enter or exit the origin or destination of travel or to comply with other requirements necessary to travel to or attend approved educational and administrative conferences, seminars, or meetings shall be reimbursed upon submittal of receipts. The cost of membership in TSA Pre, Global Entry, NEXUS, SENTRI, or other expedited security and border processing programs shall be reimbursed upon submittal of receipts. Technology needs, for both international and domestic travel, may be discussed with the LACERA Systems Division in advance to develop appropriate solutions for the Trustee's needs and to manage cost.

Reimbursement for lost or damaged property is subject to a separate policy to be developed.

APPENDIX B
TRAVEL ATTESTATION

As a LACERA Board Trustee, I acknowledge:

a. I have received, read, and understand all of the provisions within the Trustee Travel Policy; and

b. I attest my commitment to act responsibly and prudently in the best interest of LACERA members, in all travel-related matters.

_____
LACERA Board

_____
Name

_____
Signature

_____
Date

LACERA

December 20, 2022

TO: Each Trustee,
Board of Retirement

FROM: Louis Gittens, Interim Division Manager
Benefits Division

Allan Cochran, Division Manager
Member Services Division

FOR: January 4, 2023 Board of Retirement Meeting

SUBJECT: Retirement Date Adjustment

Supervisor Sheila Kuehl submitted a written application to retire December 5, 2022, which was also her last day as an elected County official. Since December 5, 2022 was her last date of County employment, her first eligible date of retirement should have been December 6, 2022. This oversight was the result of a misunderstanding on LACERA's part.

We have implemented additional steps of review for elected County officials to ensure the proper processing of retirement dates and applications are confirmed.

THEREFORE, IT IS RECOMMENDED the Board of Retirement approve the adjustment of Supervisor Sheila Kuehl's date of retirement to December 6, 2022.

NOTED AND REVIEWED:

JJ Popowich
Assistant Executive Officer

SHK:JJ

LACERA

FOR INFORMATION ONLY

December 22, 2022

TO: Each Trustee
Board of Retirement

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: January 4, 2023 Board of Retirement Meeting

SUBJECT: **State Legislative Update**

LACERA's state legislative advocates last gave an update to the Board of Retirement on June 1, 2022. Our legislative advocates, Shari McHugh and Naomi Padron of McHugh Koepke & Associates, are here today to provide an educational update of the California State Legislature after the recent midterm elections and looking ahead into 2023.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

Attachment
Presentation – State Legislative Update

cc: Santos H. Kreimann
Luis Lugo
JJ Popowich
Laura Guglielmo
Steven P. Rice
Shari McHugh, McHugh Koepke & Associates
Naomi Padron, McHugh Koepke & Associates

Los Angeles County Employees Retirement Association Board of Retirement Meeting January 2023

Shari McHugh | Naomi Padron
McHugh Koepke & Associates

Our Team

McHugh Koepke & Associates

- Sacramento-based contract lobbying firm, originally established in 2000.
- Specialize in advocacy, public affairs, research, and analysis.
- The firm has five team members:

  Shari McHugh
  Naomi Padron
  Ana Mora
  Gavin McHugh
  Dawn Koepke

- Collectively we have decades of experience

California's General Election Recap

The ballot included:

- Seven statewide propositions
- Contests for all Constitutional Officers
- Board of Equalization members
- A seat in the U.S. Senate
- Several competitive bids for the U.S. House of Representatives and the State Legislature
- Dozens of high-profile local races

Voter Turnout:

- 50.80% of Registered Voters

Senate

32 Democrats to

8 Republicans

10 new members

(including 3 Assemblymembers

moving to the Senate)

***In SD 16, Melissa Hurtado (D- Sanger) was sworn into office on December 10th. However, her challenger David Shepard (R) announced that he has requested a recount, following the certification of results with a 20-vote margin out of over 136,000 votes cast.*

Assembly

62 Democrats to

18 Republicans

24 new members

Senate Leadership

President pro Tempore
Toni G. Atkins (D-San Diego)

Senate Minority Leader
Brian Jones (R- Santee)

Assembly Leadership

House Resolution 1

Current Speaker Anthony Rendon was elected as the Speaker to serve until June 30th

Assemblymember Robert Rivas is the Speaker-designee and is elected as the Speaker to be sworn in on June 30th

Assembly Republican Leader James Gallagher (Yuba City)

Assemblymember Tina McKinnor (D-Inglewood)

Chair of the Assembly Committee on Public Employment and Retirement

- Appointed by Speaker Anthony Rendon on December 16th
- Elected to the Assembly in June 2022
- Representing AD 16 which includes the cities and communities of El Segundo, Gardena, Hawthorne, Inglewood, Lawndale, Lenox, Los Angeles, Marina del Rey, Venice, West Athens, Westchester and Westmont in Los Angeles County.
- Introduced AB 1, which would allow legislative staff the choice to join a union and collectively bargain for wages, benefits and working conditions

Key Dates

- December 5th — 2023-24 Regular Session convened
- January 4th — Legislature reconvenes
- January 10th — Budget must be submitted by Governor
- January 20th — Last day to submit bill requests to Legislative Counsel
- February 17th — Last day for bills to be introduced

State Budget

The Legislative Analyst's Office (LAO) predicts the Legislature would face a deficit of $25 billion in 2023-24.

The budget problem is mainly attributable to lower revenue estimates, which are lower than budget act projections from 2021-22 through 2023-24 by $41 billion.

Over the subsequent years of the forecast, annual deficits would decline from $17 billion to $8 billion.

Questions?

Shari McHugh
Legislative Advocate
Partner

Naomi Padron
Legislative Advocate
Associate

THANK YOU

McHugh Koepke & Associates

915 L Street, Suite 1250

Sacramento, California 95814

Phone (916) 930-1993

https://www.mchughgr.com/

LACERA

FOR INFORMATION ONLY

December 22, 2022

TO: Each Trustee
Board of Retirement

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: January 4, 2023, Board of Retirement Meeting

SUBJECT: **Application Processing Time Snapshot Reports**

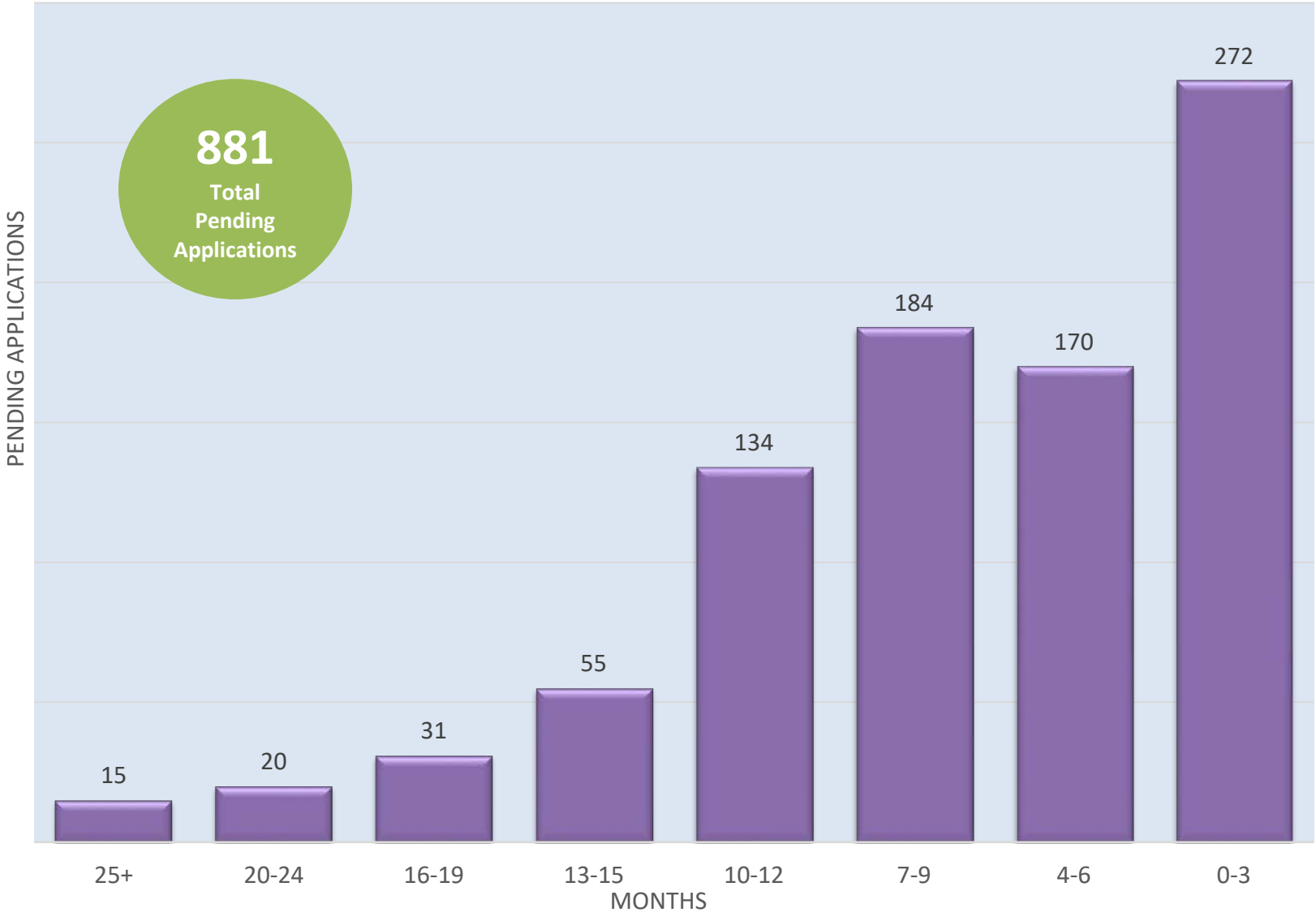
The following chart shows the total processing time from receipt of the application to the first Board action for all cases on the January 4, 2023, Disability Retirement Applications Agenda.

Consent & Non-Consent Calendar	
Number of Applications	59
Average Processing Time (in Months)	13.29
Revised/Held Over Calendar	
Number of Applications	1
Processing Time Per Case (in Months)	Case 1 34
Total Average Processing Time All 60 **Cases** on Agenda	13.63

DISABILITY RETIREMENT SERVICES
Application Processing Time

January 4, 2023 Disability Agenda

DISABILITY RETIREMENT SERVICES
Pending Applications/Months



As of December 22, 2022

LACERA

FOR INFORMATION ONLY

December 21, 2022

TO: Each Trustee
Board of Retirement
Board of Investments

FROM: Ted Granger TG
Interim Chief Financial Officer

FOR: January 4, 2023 Board of Retirement Meeting
January 11, 2023 Board of Investments Meeting

SUBJECT: **MONTHLY TRAVEL & EDUCATION REPORT – NOVEMBER 2022**

Attached for your review is the Trustee Travel & Education Report. This report includes all events (i.e., attended and canceled) from the beginning of the fiscal year through November 2022. Staff travel and education has been omitted from this document and reported to the Chief Executive Officer separately.

REVIEWED AND APPROVED:

Santos H. Kreimann
Chief Executive Officer

TG/EW/SC/wg

Attachments

c: L. Lugo
J. Popowich
L. Guglielmo
J. Grabel
S. Rice
R. Van Nortrick

LACERA

TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2022 - 2023

NOVEMBER 2022

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Alan Bernstein				
A	1	Edu - CII Fall 2022 Conference - Boston MA	09/21/2022 - 09/23/2022	Attended
	2	Edu - NCPERS 2022 Public Safety Conference - Nashville TN	10/23/2022 - 10/26/2022	Attended
B	-	Edu - SACRS 2022 Fall Conference - Long Beach CA	11/08/2022 - 11/11/2022	Attended
V	-	Edu - NACD: The Theranos Implosion - VIRTUAL	09/28/2022 - 09/28/2022	Attended
Elizabeth Ginsberg				
B	-	Edu - 2022 Board of Investments Offsite - Long Beach CA	09/13/2022 - 09/14/2022	Attended
Vivian Gray				
A	1	Edu - CII Fall 2022 Conference - Boston MA	09/21/2022 - 09/23/2022	Attended
B	-	Edu - NCPERS 2022 Public Pension Funding Forum - Los Angeles CA	08/21/2022 - 08/23/2022	Attended
	-	Admin - SACRS Board of Directors Meeting - Los Angeles CA	08/22/2022 - 08/22/2022	Attended
	-	Edu - 2022 Board of Investments Offsite - Long Beach CA	09/13/2022 - 09/14/2022	Attended
	-	Admin - SACRS Program Committee & Board of Directors Meeting - Santa Barbara CA	09/26/2022 - 09/27/2022	Attended
	-	Edu - SACRS 2022 Fall Conference - Long Beach CA	11/08/2022 - 11/11/2022	Canceled
V	-	Edu - The Global Conversation on Gender Diversity - VIRTUAL	11/02/2022 - 11/02/2022	Attended
	-	Edu - 50/50 Women on Boards - VIRTUAL	11/02/2022 - 11/02/2022	Attended
X	-	Edu - TLF Annual Convening 2022 - Cambridge MA	07/18/2022 - 07/20/2022	Canceled
David Green				
A	1	Edu - PPI 2022 Summer Roundtable - Canada, Vancouver	07/13/2022 - 07/15/2022	Attended
B	-	Edu - 2022 Board of Investments Offsite - Long Beach CA	09/13/2022 - 09/14/2022	Attended
	-	Edu - SACRS 2022 Fall Conference - Long Beach CA	11/08/2022 - 11/11/2022	Attended
Elizabeth Greenwood				
A	1	Edu - 16th Annual Small and Emerging Managers (SEM) Conference - Chicago IL	10/12/2022 - 10/13/2022	Attended
Onyx Jones				
A	1	Edu - SACRS Public Pension Investment Management Program - San Francisco CA	07/17/2022 - 07/20/2022	Attended
	2	Edu - 2022 CALAPRS Principles of Pension Governance for Trustees - Tiburon CA	08/29/2022 - 09/01/2022	Attended
B	-	Edu - 2022 Board of Investments Offsite - Long Beach CA	09/13/2022 - 09/14/2022	Attended
	-	Edu - Women in Institutional Investments Network - Los Angeles CA	10/12/2022 - 10/12/2022	Attended
V	-	Edu - The World to Africa Webinar - VIRTUAL	07/27/2022 - 07/27/2022	Attended

LACERA

TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2022 - 2023

NOVEMBER 2022

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Patrick Jones				
A	1	Edu - Leading in Artificial Intelligence: Exploring Technology and Policy - Harvard Kennedy School - Cambridge MA	07/17/2022 - 07/22/2022	Attended
B	-	Edu - 2022 Board of Investments Offsite - Long Beach CA	09/13/2022 - 09/14/2022	Attended
	-	Edu - SACRS 2022 Fall Conference - Long Beach CA	11/08/2022 - 11/11/2022	Attended
Shawn Kehoe				
V	-	Edu - 2022 Board of Investments Offsite - VIRTUAL	09/13/2022 - 09/14/2022	Attended
Joseph Kelly				
A	1	Edu - PPI Executive Seminar and the Asia Pacific Roundtable - Singapore	10/16/2022 - 10/21/2022	Attended
	2	Edu - CII-NYU Corporate Governance Bootcamp - New York NY	11/16/2022 - 11/18/2022	Attended
V	-	Edu - NACD Conflict, Climate, Cyber: What's Next? - VIRTUAL	08/23/2022 - 08/23/2022	Attended
	-	Edu - 2022 Board of Investments Offsite - VIRTUAL	09/13/2022 - 09/14/2022	Attended
	-	Edu - NACD Risk Mitigation Through Board Quality and Compliance Committees: Lessons from Theranos - VIRTUAL	09/28/2022 - 09/28/2022	Attended
	-	Edu - Institute of Internal Auditors 2022 Cybersecurity Virtual Conference - VIRTUAL	10/27/2022 - 10/27/2022	Attended
Keith Knox				
B	-	Edu - 2022 Board of Investments Offsite - Long Beach CA	09/13/2022 - 09/14/2022	Attended
V	-	Edu - What Makes an Effective Trustee - VIRTUAL	11/16/2022 - 11/16/2022	Attended
William Pryor				
A	1	Edu - NCPERS 2022 Public Safety Conference - Nashville TN	10/23/2022 - 10/26/2022	Attended
B	-	Edu - NCPERS 2022 Public Pension Funding Forum - Los Angeles CA	08/21/2022 - 08/23/2022	Attended
Les Robbins				
B	-	Edu - SACRS 2022 Fall Conference - Long Beach CA	11/08/2022 - 11/11/2022	Attended
Gina Sanchez				
A	1	Edu - PPI Executive Seminar and the Asia Pacific Roundtable - Singapore	10/16/2022 - 10/21/2022	Attended
B	-	Edu - NCPERS 2022 Public Pension Funding Forum - Los Angeles CA	08/21/2022 - 08/23/2022	Attended
	-	Edu - 2022 Fall Editorial Advisory Board Meeting – Institutional Real Estate Americas - Pasadena CA	09/06/2022 - 09/08/2022	Attended
	-	Edu - 2022 Board of Investments Offsite - Long Beach CA	09/13/2022 - 09/14/2022	Attended
	-	Edu - SACRS 2022 Fall Conference - Long Beach CA	11/08/2022 - 11/11/2022	Attended
	-	Edu - 2022 Toigo Foundation Gala - Los Angeles CA	11/17/2022 - 11/17/2022	Attended
V	-	Edu - NACD Summit 2022 - VIRTUAL	10/08/2022 - 10/11/2022	Attended

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TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2022 - 2023

NOVEMBER 2022

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Herman Santos				
A	1	Edu - PPI 2022 Summer Roundtable - Canada, Vancouver	07/13/2022 - 07/15/2022	Attended
	2	Edu - CII Fall 2022 Conference - Boston MA	09/21/2022 - 09/23/2022	Attended
	3	Edu - 2022 AAAIM Elevate National Conference - New York NY	09/28/2022 - 09/30/2022	Attended
B	-	Edu - 2022 Board of Investments Offsite - Long Beach CA	09/13/2022 - 09/14/2022	Attended
	-	Edu - SACRS 2022 Fall Conference - Long Beach CA	11/08/2022 - 11/11/2022	Canceled
	-	Edu - 2022 Toigo Foundation Gala - Los Angeles CA	11/17/2022 - 11/17/2022	Attended

Category Legend:
A - Pre-Approved/Board Approved
B - Educational Conferences and Administrative Meetings in CA where total cost is no more than $2,000 per Trustee Travel Policy; Section III.A
C - Second of two conferences and/or meetings counted as one conference per Trustee Education Policy Section IV.C.2 and Trustee Travel Policy Section IV.
V – Virtual Event
X - Canceled events for which expenses have been incurred.
Z - Trip was Canceled - Balance of $0.00

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