LIVE VIRTUAL BOARD MEETING

JULY 6, 2022 AT 9:00 AM*

BOARD OF RETIREMENT MEETING

*This meeting will take place following the Operations Oversight Committee meeting being held prior.

TO VIEW VIA WEB

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

TO PROVIDE PUBLIC COMMENT

You may submit a request to speak during Public Comment or provide a written comment by emailing PublicComment@lacera.com. If you would like to remain anonymous at the meeting without stating your name, please let us know.

Attention: Public comment requests must be submitted via email to PublicComment@lacera.com.

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

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, JULY 6, 2022*

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

Any person may view the meeting 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.

I. CALL TO ORDER

II. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of June 1, 2022

III. PUBLIC COMMENT

(Written Public Comment - You may submit written public comments by email to PublicComment@lacera.com. Correspondence will be made part of the official record of the meeting. Please submit your written public comments or documentation as soon as possible and up to the close of the meeting.

Verbal Public Comment - You may also request to address the Board at PublicComment@lacera.com before and during the meeting at any time up to the end of the Public Comment item. We will contact you with information and instructions as to how to access the meeting as a speaker. If you would like to remain anonymous at the meeting without stating your name, please let us know.)

IV. OTHER COMMUNICATIONS

A. For Information

1. May 2022 All Stars

2. Chief Executive Officer's Report
(Memo dated June 28, 2022)

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

VI. CONSENT ITEMS

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 the County of Los Angeles and other agencies still recommend social distancing such that each Board and its Committees shall hold teleconference meetings for the next 30 days, subject to continuation of the State of Emergency, 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. (Memo dated June 27, 2022)

B. Ratification of Service Retirement and Survivor Benefit Application Approvals. (Memo dated June 28, 2022)

C. Recommendation as submitted by Les Robbins, Chair, Insurance, Benefits and Legislative Committee: That the Board adopt a "Neutral" position on Assembly Bill 2493, which would make adjustments to retirement payments based on disallowed compensation. (Memo dated June 22, 2022)

D. Recommendation as submitted by Ricki Contreras, Division Manager, Disability Retirement Services: That the Board grant the appeal and request for an administrative hearing for applicants Michael G. Metal and An L. Ning. (Memo dated June 22, 2022)

E. Recommendation as submitted by Ricki Contreras, Division Manager, Disability Retirement Services: That the Board approve the applications of Stanley J. Majcher, M.D. – Internal Medicine/Gastroenterology; Samuel A. Berkman, M.D. – Internal Medicine/Oncology; Steven N. Brourman, M.D. – Orthopedic/Hand Surgery; Jonathan C. Green, M.D. – Internal Medicine/Occupational Medicine; Robert B. Weber, M.D. – Internal Medicine/Cardiovascular Medicine; and Paul J. Grodan, M.D. - Internal Medicine/Cardiology to the LACERA Panel of Examining Physicians. (Memo dated June 14, 2022)

VI. CONSENT ITEMS (Continued)

F. Recommendation as submitted by Ricki Contreras, Division Manager, Disability Retirement Services: That the Board dismiss with prejudice the appeal of Alvin D. Poff, Jr. for a service-connected disability retirement. (Memo dated June 23, 2022)

VII. EXCLUDED FROM CONSENT ITEMS

VIII. REPORTS

A. Presentation by Legislative Advocates, Tony Roda from Williams & Jensen, PLLC and Shane Doucet from Doucet Consulting Solutions, regarding the Federal Legislative Update. (Memo dated June 22, 2022)

B. Presentation by JJ Popowich, Assistant Executive Officer; Kelly Puga, Contact Center Manager; Gerald Bucacao, Sr. Retirement Benefit Specialist; Valerie Quiroz, Sr. Retirement Benefit Specialist; and Renee Copeland, Sr. Retirement Benefit Specialist, regarding Member Services Call Center Wait Time. (Memo dated June 28, 2022)

C. For Information Only as submitted by Luis A. Lugo, Deputy Chief Executive Officer, regarding the SEIU Local 850/851 Meeting Held on May 25, 2022. (Memo dated June 29, 2022)

D. For Information Only as submitted by Barry W. Lew, Legislative Affairs Officer, regarding the Monthly Status Report on Legislation. (Memo dated June 26, 2022)

E. For Information Only as submitted by Francis J. Boyd, Senior Staff Counsel, regarding LACERA's Procedures for Disability Retirement Hearings Update Presentation for Referees, Applicant Attorneys, and Staff. (Memo dated June 24, 2022)

F. For Information Only as submitted by Ricki Contreras, Division Manager, Disability Retirement Services, regarding the Application Processing Time Snapshot Reports. (Memo dated June 22, 2022)

VIII. REPORTS (Continued)

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

Monthly Trustee Travel and Education Reports for May 2022
(Public memo dated June 22, 2022)
(Confidential memo dated June 22, 2022 – Includes Anticipated Travel)

H. For Information Only as submitted by Christine Roseland, Senior Staff Counsel, regarding the Legal Transactions Year End Report.
(Memo dated May 31, 2022)

I. For Information Only as submitted by Steven P. Rice, Chief Counsel, regarding the June 2022 Fiduciary Counsel Contact and Billing Report.
(Memo dated June 27, 2022) (Privileged and Confidential Attorney-Client Communication/Attorney Work Product)

IX. ITEMS FOR STAFF REVIEW

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

XI. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability

B. Staff Recommendations

1. Recommendation as submitted by Allison E. Barrett, Senior Staff Counsel, Disability Litigation Division: Pursuant to Government Code section 31533, it is recommended that the Board refer the matter to a LACERA Referee to weigh the evidence on the limited issue of (1) whether Gerard R. Smith can prove he was permanently incapacitated prior to the earliest date of commission of the felony for which he was convicted, August 18, 2011, and therefore eligible for disability retirement benefits; or, (2) whether he was permanently incapacitated after August 18, 2011, and therefore not entitled to disability retirement benefits, in accordance with the felony forfeiture statute, Government Code section 7522.72. (Memo dated June 9, 2022)

XI. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

B. Staff Recommendations (Continued)

2. Recommendation as submitted by Jason E. Waller, Senior Staff Counsel, Disability Litigation Division: Pursuant to Government Code section 31533, it is recommended that the Board refer the matter to a LACERA Referee to weigh the evidence on the limited issue of: (1) whether Stephen E. Leavins can prove he was permanently incapacitated prior to the earliest date of commission of the felony for which he was convicted, August 18, 2011, and therefore eligible for disability retirement benefits; or (2) whether he was permanently incapacitated after August 18, 2011, and therefore not entitled to disability retirement benefits, in accordance with the felony forfeiture statute, Government Code section 7522.72. (Memo dated June 9, 2022)

3. Recommendation as submitted by Ricki Contreras Division Manager, Disability Retirement Services: That the Board adopt the Proposed Findings of Fact and Conclusions of Law granting Cynthia A. Campbell a service-connected disability retirement pursuant to Government Code Section 31720.
(Memo dated June 23, 2022)

4. Recommendation as submitted by Ricki Contreras Division Manager, Disability Retirement Services: That the Board approve the service provider invoice for Referee Irene P. Ayala.
(Memo dated June 21, 2022)

XII. 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.

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

9:00 A.M., WEDNESDAY, JUNE 1, 2022

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

PRESENT: William Pryor (Alternate Safety), Chair

Shawn R. Kehoe, Vice Chair (Joined the meeting at 9:23 a.m.)

Alan Bernstein, Secretary (Joined the meeting at 10:16 a.m.)

Vivian H. Gray

JP Harris (Alternate Retired)

Keith Knox

Wayne Moore (Left the meeting at 10:00 a.m.)

Les Robbins

Antonio Sanchez

Herman Santos

ABSENT: Gina Zapanta

STAFF ADVISORS AND PARTICIPANTS

Santos H. Kreimann, Chief Executive Officer

Luis A. Lugo, Deputy Chief Executive Officer

JJ Popowich, Assistant Executive Officer

Laura Guglielmo, Assistant Executive Officer

STAFF ADVISORS AND PARTICIPANTS (Continued)

Steven P. Rice, Chief Counsel

Dr. Glenn Ehresmann, Medical Advisor

Cassandra Smith, Retiree Healthcare Director

Ted Granger, Interim Chief Financial Officer

Carly Ntoya, Ph.D., Human Resources Director

Carlos Barrios, Interim Benefits Manager

Barry W. Lew, Legislative Affairs Officer

Francis J. Boyd, Senior Staff Counsel

Ricki Contreras, Disability Retirement Services Division 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

Eugenia Der, Senior Staff Counsel

Allison E. Barrett, Senior Staff Counsel

Jason Waller, Senior Staff Counsel

I. CALL TO ORDER

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

II. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of May 5, 2022

Mr. Knox made a motion, Mr. Santos seconded, to approve the minutes of the regular meeting of May 5, 2022. The motion passed (roll call) with Messrs. Santos, Knox, Sanchez, Robbins, Moore, Pryor, and Ms. Gray voting yes. Mr. Kehoe, Bernstein, and Ms. Zapanta were absent for the vote.

III. PUBLIC COMMENT

There were no requests from the public to speak.

IV. OTHER COMMUNICATIONS

A. For Information

1. April 2022 All Stars

Mr. Popowich announced the winners for the month of April: Edson Yu, Ian Duggan, Sarah Scott, and Frank Staten, Rideshare winner was James Beasley, and the Web Watcher was Jeff Shevlowitz.

2. Chief Executive Officer's Report
(Memo dated May 24, 2022)

Mr. Kreimann provided the Board with an update on the strategic planning efforts and staff's return to the office via a hybrid work schedule. Furthermore, he shared that the Board Chairs and Vice Chairs will be meeting to discuss the timing of a hybrid return for Trustees based on the request shared at the May Board of Investments meeting.

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Law Enforcement
Service-Connected Disability Applications

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

APPLICATION NO.		NAME
695D		MICHAEL H. BERBIAR
696D	*	PAUL W. HARDY
697D		ALBERT J. VITA
698D		KYLE C. SWORD
699D		JOSHUA M. RANDENBERG
700D		JOHN B. MUNDELL
701D		MARK A. GITTENS
702D		GEORGE GUERRA
703D		ANGEL FONSECA
704D		SHAWN C. HORNING
705D		ANTHONY F. DIVITA

*Granted SCD – Employer Cannot Accommodate

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Law Enforcement (Continued)
Service-Connected Disability Applications

APPLICATION NO.	NAME
706D	MICHAEL R. WRIGHT
707D	DENNIS J. MISSEL
708D	DANNY CHAVEZ
709D	ANGELA E. GASKIN
710D *	JAMIE J. ARAKAWA (DEC'D)
711D	MICHAEL A. SELLERS
712D	SALVADOR V. ESCOBEDO
713D**	ROBERT J. SCHIAVONE
714D	JODILYN E. WOLFE
715D	ISAIAS MARIN, JR.
716D	RODOLFO G. CORTEZ
717D	DAVID W. JOHNSON
718D	RAYMOND LAM
719D	ROBERT J. GRAY
720D	DAVID FLORES
721D	ARMANDO R. HERNANDEZ, JR.

*Granted SCD – Survivor Benefit
**Granted SCD – Retroactive

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Law Enforcement (Continued)
Service-Connected Disability Applications

APPLICATION NO.	NAME
722D	CATHERINE R. BENNETT
723D	BRYAN E. RILEY
724D	JESUS M. RODRIGUEZ, JR.
725D	RONNIE L. MANIER
726D*	ENRIQUE CARRILLO
727D	MICHAEL M. HARDING
728D	FERNANDO ANAYA
729D	KELLY A. SIMON

Safety Fire, Lifeguards
Service-Connected Disability Applications

On a motion by Mr. Pryor, 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. Knox, Santos, Sanchez, Moore, Robbins, Pryor, and Ms. Gray voting yes. Messrs. Kehoe, Bernstein and Ms. Zapanta were absent for the vote.

APPLICATION NO.	NAME
1477B	LEWIS R. CURRIER

*Granted SCD – Retroactive

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Fire, Lifeguards (Continued)
Service-Connected Disability Applications

APPLICATION NO.	NAME
1478B	NINO A. VANILLO
1479B*	LARRY SOTELO
1480B	DAVID J. PACHECO
1481B	JOHN R. PRICE II
1482B	THOMAS J. MAY
1483B	PHILIP D. SCHNEIDER
1484B	ROBERT A. FUNKE

General Members
Service-Connected Disability Applications

On a motion by Mr. Santos, 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. Knox, Santos, Sanchez, Moore, Robbins, Pryor, and Ms. Gray voting yes. Messrs. Kehoe, Bernstein and Ms. Zapanta were absent for the vote.

APPLICATION NO.	NAME
2386C*	GUS P. KOWAL

*Granted SCD – Retroactive

V. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

General Members (Continued)
Service-Connected Disability Applications

APPLICATION NO.	NAME
2387C*	PRISCILLA D. ALOG
2388C*	EMMA ZESATI
2389C	TERRY KUO
2390C	GLADYS E. MADDIN
2391C**	DAVID E. LEE
2392C**	JONNIE L. COLLINS
2393C**	TAMMIE S. BAHAM
2394C*	LATANIA G. WILSON
2395C***	MYSHAUNA M. ALEXANDER
2396C*	ANNETTE BRYANT
2397C	MARK H. BORGESON
2398C*	STEPHANIE GONZALEZ
2399C**	DORA HERRERA-RODRIGUEZ

*Granted SCD – Salary Supplement
**Granted SCD – Employer Cannot Accommodate
***Granted SCD – Salary Supplement Since Employer Cannot Accommodate

VI. CONSENT ITEMS

(Mr. Kehoe joined the meeting at 9:23 a.m.)

Mr. Robbins made a motion, Mr. Kehoe seconded, to approve Consent Items A-G. The motion passed unanimously (roll call) with Messrs. Knox, Santos, Sanchez, Moore, Kehoe and Robbins and Ms. Gray voting yes. Mr. Bernstein and Ms. Zapanta were absent for 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 the County of Los Angeles and other agencies still recommend social distancing such that each Board and its Committees shall hold teleconference meetings for the next 30 days, subject to continuation of the State of Emergency, 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. (Memo dated May 24, 2022)

B. Ratification of Service Retirement and Survivor Benefit Application Approvals. (Memo dated May 25, 2022)

C. Recommendation as submitted by Herman B. Santos, Chair, Joint Organizational Governance Committee: That the Board approve the revised LACERA Budget Policy and review it annually as a companion to the adoption of the Administrative, Retiree Healthcare Benefits Program and Other Post- Employment Benefits Trust Budgets. (Memo dated May 20, 2022)

D. Recommendation as submitted by Herman B. Santos, Chair, Joint Organizational Governance Committee: That the Board adopt the LACERA Fiscal Year 2022-2023 Administrative, Retiree Healthcare Benefits Program and Other Post-Employment Benefits Trust Budgets. (Memo dated May 20, 2022)

VI. CONSENT ITEMS (Continued)

E. Recommendation as submitted by Les Robbins, Chair, Insurance, Benefits and Legislative Committee: That the Board adopt a "Support" position on Assembly Bill 1971, which would make various administrative amendments to the County Employees Retirement Law of 1937. (Memo dated May 20, 2022)

F. Recommendation as submitted by Ricki Contreras, Division Manager, Disability Retirement Services: That the Board grant the appeals and requests for an administrative hearing for applicants Brian D. Jordan, Maria D. Rios, Paul G. Murphy, Jose De Jesus Lopez, and Ressie L. Ducut. (Memo dated May 20, 2022)

G. Recommendation as submitted by Ricki Contreras, Division Manager, Disability Retirement Services: That the Board dismiss with prejudice Sheila R. La Bomme's appeal of the service-connected disability retirement. (Memo dated May 24, 2022)

VII. EXCLUDED FROM CONSENT ITEMS

There were no items excluded from the Consent Items.

VIII. REPORTS

A. Presentation by Legislative Advocates, Shari McHugh and Naomi Padron of McHugh Koepke & Associates, regarding the State Legislative Update. (Memo dated May 20, 2022)

Ms. McHugh and Ms. Padron gave a presentation and answered

questions from the Board. The presentation was received and filed.

B. Presentation by Frank Boyd, Senior Staff Counsel, regarding the Board of Retirement's Role as Trier of Fact in Disability Retirement Applications. (Presentation dated June 1, 2022) (Mr. Moore left the meeting at 10 a.m.)

Mr. Boyd gave a presentation and answered questions from the Board.

The presentation was received and filed.

VIII. REPORTS (Continued)

The following items were received and filed.

C. For Information Only as submitted by Ricki Contreras, Division Manager, Disability Retirement Services, regarding the Application Processing Time Snapshot Reports. (Memo dated May 24, 2022)

D. For Information Only as submitted by Barry W. Lew, Legislative Affairs Officer, regarding the Monthly Status Report on Legislation. (Memo dated May 20, 2022)

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

3rd Quarter Trustee Travel and Education Reports
(Memo dated May 17, 2022)

Monthly Trustee Travel and Education Reports for April 2022
(Public Memo dated May 16, 2022)
(Confidential Memo dated May 16, 2022 – Includes Anticipated Travel)

F. For Information Only as submitted by Steven P. Rice, Chief Counsel, regarding the May 2022 Fiduciary Counsel Contact and Billing Report. (Memo dated May 23, 2022) (Privileged and Confidential Attorney-Client Communication/Attorney Work Product)

IX. ITEMS FOR STAFF REVIEW

The Board requested that the topic of employee salary negotiations be agendized for a future meeting.

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

There was nothing to report.

XII. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability
(Mr. Bernstein joined the meeting at 10:16 a.m.)

APPLICATION NO. & NAME	BOARD ACTION
5255B – TODD J. DOW	Mr. Harris made a motion, Ms. Gray seconded, to grant a nonservice-connected disability retirement salary supplement pursuant to Government Code Sections 31720 and 31725.5. The motion passed unanimously (roll call) with Messrs. Knox, Santos, Sanchez, Robbins, Kehoe, Bernstein, and Ms. Gray voting yes. Mr. Moore and Ms. Zapanta were absent from the vote.
5256B – THOMAS M. SHANNON	Mr. Robbins made a motion, Ms. Gray seconded, to deny a service-connected disability retirement pursuant to Government Code Section 31722. The motion passed unanimously (roll call) with Messrs. Knox, Santos, Sanchez, Robbins, Kehoe, Bernstein, and Ms. Gray voting yes. Mr. Moore and Ms. Zapanta were absent from the vote.
5257B – MICHAEL J. FOURNIER (DEC'D)*	Ms. Gray made a motion, Mr. Pryor seconded, to deny a service-connected death survivor benefit. The motion passed unanimously (roll call) with Messrs. Knox, Santos, Sanchez, Robbins, Pryor, Bernstein, and Ms. Gray voting yes. Messrs. Moore, Kehoe and Ms. Zapanta were absent from the vote.

* Applicant's Attorney Present

XII. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability (Continued)

APPLICATION NO. & NAME	BOARD ACTION
5258B – SHANNON K. EBERLY	Mr. Harris made a motion, Mr. Knox seconded, to grant a nonservice-connected disability retirement salary supplement pursuant to Government Code Sections 31720 and 31725.5. The motion passed unanimously (roll call) with Messrs. Knox, Santos, Sanchez, Robbins, Kehoe, Bernstein, and Ms. Gray voting yes. Mr. Moore and Ms. Zapanta were absent from the vote.
5186B – TIMOTHY P. FINN*	Mr. Kehoe made a motion, Mr. Knox seconded, to grant a nonservice-connected disability retirement without prejudice pursuant to Government Code Sections 31720 and 31724. Mr. Pryor made a substitute motion, Ms. Gray seconded, to refer back to staff for further development. The motion passed unanimously (roll call) with Messrs. Knox, Santos, Sanchez, Robbins, Pryor, Bernstein, and Ms. Gray voting yes. Messrs. Moore, Kehoe and Ms. Zapanta were absent from the vote.
5251B – DANA NGO	Mr. Harris made a motion, Ms. Gray seconded, to grant a nonservice-connected disability retirement pursuant to Government Code Sections 31720 and 31724. The motion passed unanimously (roll call) with Messrs. Knox, Santos, Sanchez, Robbins, Kehoe, Bernstein, and Ms. Gray voting yes. Mr. Moore and Ms. Zapanta were absent from the vote.

* Applicant's Attorney Present

XII. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability (Continued)

APPLICATION NO. & NAME	BOARD ACTION
5224B – DAVID B. CAMPS (DEC'D)*	Mr. Kehoe made a motion, Ms. Gray seconded, to grant a service-connected death survivor benefit. The motion passed unanimously (roll call) with Messrs. Knox, Santos, Sanchez, Robbins, Kehoe, Bernstein, and Ms. Gray voting yes. Mr. Moore and Ms. Zapanta were absent from the vote.

B. Staff Recommendations

1. Recommendation as submitted by Ricki Contreras, Division Manager, Disability Retirement Services: That the Board reject the Application of Nicholas A. Moreno for processing. (Memo dated May 19, 2022)

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

XIII. ADJOURNMENT

There being no further business to come before the Board, the meeting was adjourned at 10:57 a.m.

* Applicant's Attorney Present

_____
ALAN BERNSTEIN, SECRETARY

_____
WILLIAM PRYOR, CHAIR

LACERA

June 28, 2022

TO: Each Trustee,
Board of Retirement
Board of Investments

FROM: Santos H. Kreimann
Chief Executive Officer

SUBJECT: **CHIEF EXECUTIVE OFFICER'S REPORT – JULY 2022**

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

Strategic Plan Update

The LACERA Strategic Planning process is continuing to progress smoothly. Over the past month, the Advisory (Spark) team agreed upon the strategic priorities and formulated seven Action Planning Teams (APTs) to further outline specific objectives and tactics. All LACERA staff were invited to participate with a goal of six to ten participants for each APT. In total, 65 staff from entry level to managers, representing every Division, have agreed to participate. Most volunteers received their first choice. KH Consulting Group will provide the APT orientation in the last week of June.

Additionally, a member survey has been developed and will be sent to all members, active and retired, on July 14th. Members will have four weeks to complete the survey online (preferred), or mail it in. LACERA Management has also been working with the County to send the survey electronically to all active County employees. This stakeholder engagement is a critical part of the strategic planning process.

The findings and recommendations that come from the APTs, as well as member engagement surveys, will be presented to the Advisory team in September. KH Consulting and The Advisory team will continue to provide periodic updates on our Strategic Planning milestones, keeping staff and members regularly informed of important Strategic Planning information, dates, activities, and status updates throughout the process.

Cost of Living Adjustment Update

The Board of Supervisors administratively approved the successor Memorandum of Understanding (MOU) for LACERA represented employees and related salary and fringe benefit changes for LACERA non-represented employees during their June 28, 2022 meeting. LACERA will act quickly to initiate the one-time bonus of $1,000, and to process retroactive pay increases for LACERA's staff effective January 1, 2022.

2022 Safety Member Elections

Elections will be held Friday, August 5 through Wednesday, August 31, 2022 for the safety member trustee seats on both boards. The positions are: seventh trustee seat and alternate safety trustee seat on the Board of Retirement, and the fourth trustee seat on the Board of Investments. The trustees' three-year terms will run from 2023 through 2025.

The Executive Office of the Board of Supervisors recently notified LACERA that the Registrar Recorder has certified three candidates for both the seats available on the Board of Retirement and on the Board of Investments. The three candidates are as follows:

Seventh Member and Alternate Safety Member, Board of Retirement:

Jason E. Green
Shawn R. Kehoe
David Lucky Ly

Fourth Member, Board of Investments:

Jason E. Green
Shawn R. Kehoe
David Lucky Ly

LACERA's Communication Division continues to work with the Executive Office of the Board of Supervisors to update Safety members on the election. We will share future communication plans as they develop.

Recruitment Updates

Vacancies and Hiring

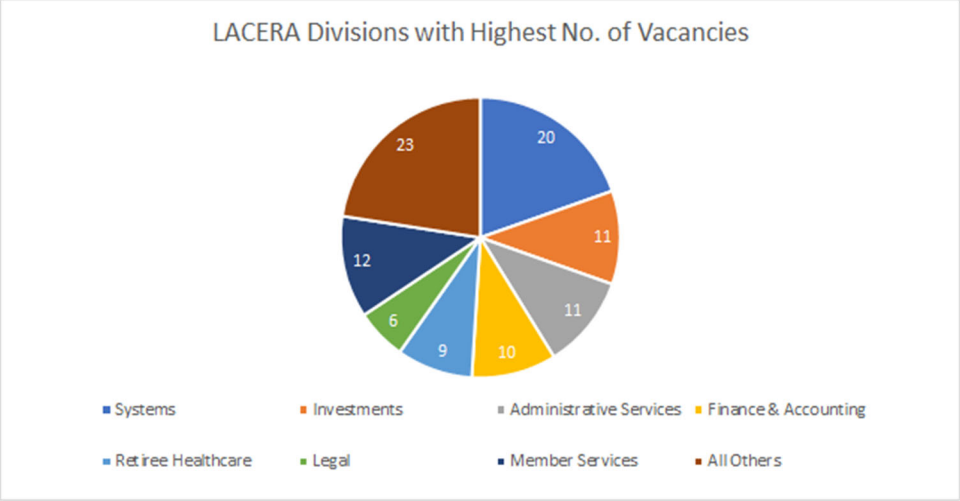
The current hiring priority in the Investments Division recruitment efforts is the Senior Investment Officer. There are eleven (11) vacancies in Investments (24% vacancy rate) and below is a summary of the recruitment status of these positions.

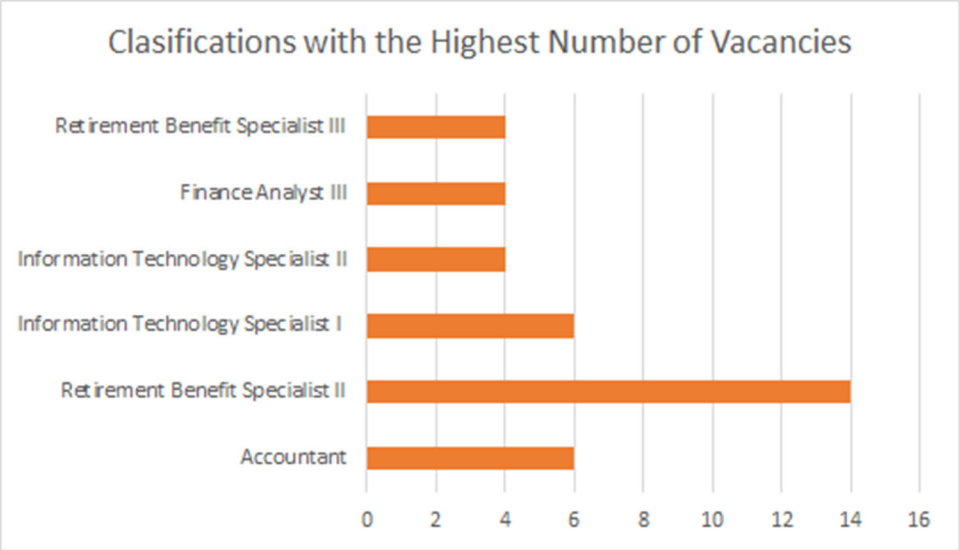
Status of Vacant Positions in the Investments Division

Classification	# of Vacancies	LACERA Priority	Recruitment Stage
Deputy Chief Investment Officer	1	Tier 2 – December 2022	Outsourced Recruitment
Senior Investment Officer (SIO)	1	Tier 1 – June 2022	7 – Assessment Review
Finance Analyst III (FA III)	4	Tier 1 – June 2022	7 – Assessment Review
Finance Analyst II (FA II)	2	Tier 2 – December 2022	1 – Exam Requested
Senior Management Secretary	1	Tier 2 – December 2022	N/A
Principal Investment Officer (PIO)	1	Tier 2 – December 2022	N/A
Senior Investment Officer	1	Unassigned	N/A

Recruitment Stages: (1) Exam requested, (2) Classification review, (3) Test development, (4) Resume canvas, (5) Recruitment, (6) Assessment qualification, (7) Assessment review, (8) List promulgated, (9) Division interviews, (10) Background check, (11) Onboarding

At the time of this report, LACERA has 508 budgeted positions, of which 102 are vacant (20% vacancy rate). The Divisions with the highest number of vacancies, and the classifications with the highest number of vacancies, are shown below.





Development

Human Resources works with the hiring Division to review the classification description, create an ideal candidate profile, and discuss the assessment process. This information is used by HR to create the job bulletin and recruiting brochure (management positions only). The recruitments/assessments continue to be in development for Accountant and Retirement Systems Specialist along with the Staff Counsel (Benefits).

Recruiting & Assessment

The Human Resources Team opened the recruitment for Staff Counsel (Investments). The recruitment for Finance Analyst III in Corporate Governance and Stewardship, Portfolio Analytics, and Real Estate, and the recruitment for Senior Investment Officer in Real Estate continue to be open for filing while applications that have already been received are in the assessment phase. The Senior Accountant exam was closed and is currently in the final assessment phase with the intent of filling the remaining vacancy.

Hiring

Three (3) offers for the Data Systems Analyst I were made, and the candidates are currently going through the background process. Three (3) offers were made for Retirement Benefits Specialist I (Temporary) for Retiree Health Care, those candidates are also currently in the background process. One (1) promotional offer from Staff Counsel to Senior Staff Counsel was accepted in the Legal Division.

Retiree Healthcare (RHC) Update

California Dental Disclosure Matrix

In early 2021, the Department of Insurance approved a regulation requiring all specialized health care services plans that cover dental services and operating in California to provide a Summary of Dental Benefits and Coverage (SDBC) Disclosure Matrix to groups offering dental coverage to their retirees.

Cigna has provided this matrix for our Dental Preferred Provider Organization (DPPO) plan. Per the regulation, this document must be made available to members either electronically or in paper format. Due to the timing of the receipt of this information, we were unable to include it in the annual premium notification packet, so it's been made available on the website.

The California Department of Managed Care (CA DMHC) has not completed its final SDBC regulation for the Dental Health Maintenance Organization (DHMO) plan. The document for the DHMO will be provided upon approval of the DMHC's final regulation and as required by the regulation.

$1 Million Lifetime Maximum Benefit (LMB) for Non-Medicare Plans - Update

LACERA staff continues to be engaged with the Board of Supervisors and County of Los Angeles CEO's office on the elimination of the $1 million Lifetime Maximum Benefit (LMB). The LMB applies to over 8,700 County active members and retirees enrolled now (or in the future) in the PPO and indemnity plan options.

On June 10, 2022, the County CEO's office, LACERA staff, LACERA's Healthcare consultant, and actuary, met to discuss the findings of the County's actuarial analysis. The County CEO's office will look to schedule a follow-up meeting after adoption of the County Budget in June to discuss next steps in addressing the $1 million LMB. We will continue to work through the situation and keep the Board apprised of any new updates or developments.

SHK
CEO report July 2022.doc

Attachments

CEO DASHBOARD

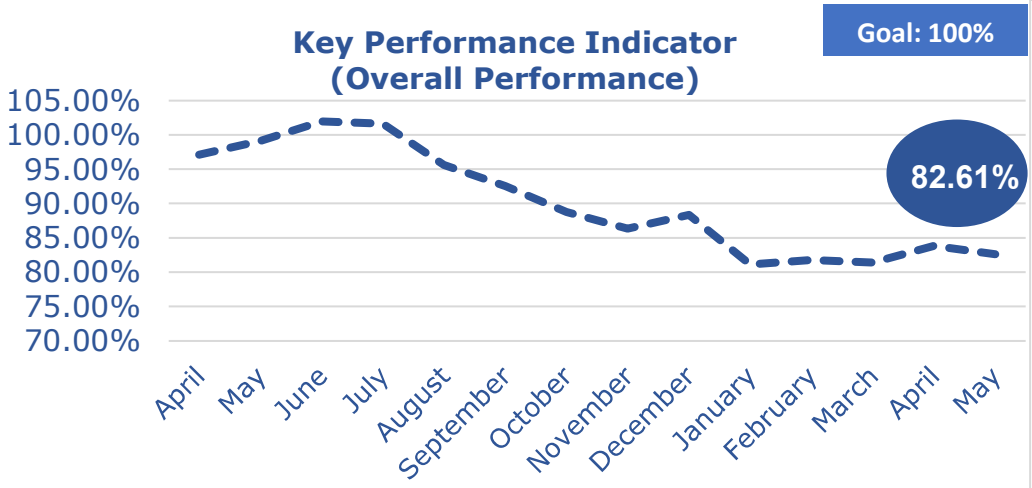
July 6, 2022

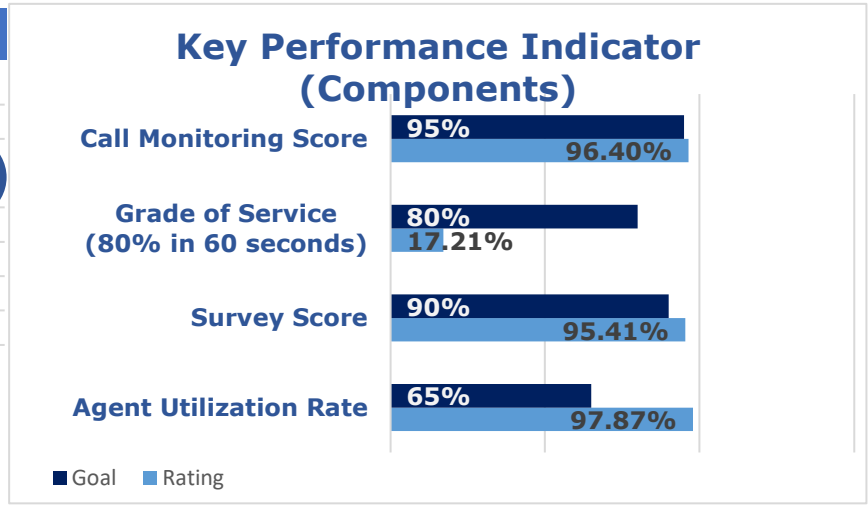
Striving for Excellence

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

WORKSHOP ATTENDANCE	OUTREACH EVENTS	WORKSHOP SATISFACTION	MSC SATISFACTION	MEMBER SERVICES CALL CENTER
1,012	20	N/A	N/A	13,272
Year-to-Date: 11,011	Year-to-Date: 192	Mo. To Mo. Change N/A	Mo. To Mo. Change N/A	3 Month Average 15,970

Member Services





Top Calls

1. Retirement Counseling: Process Overview
2. Retirement Counseling: Estimate
3. Retirement Counseling: Plan Overview

Emails

685

Avg. Response Time (ART)

24:00 hours

Secure Message

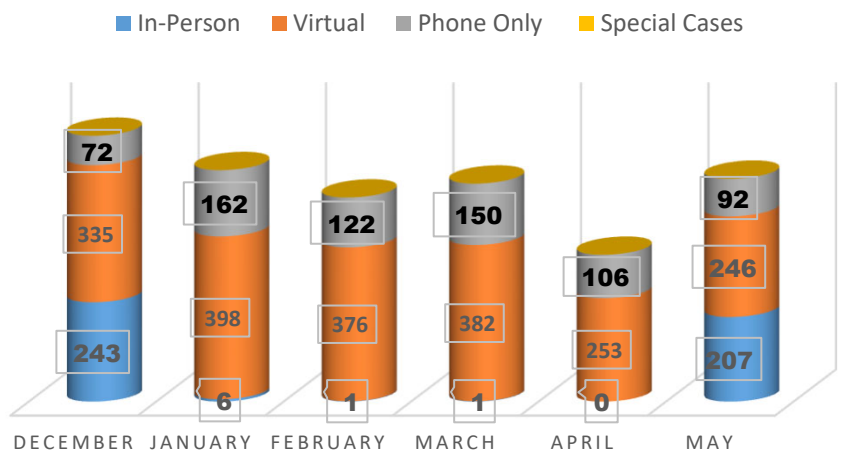
1,093

Striving for Excellence

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

Member Services

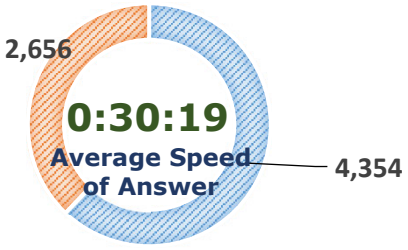
Member Service Center Appointments



COMING SOON

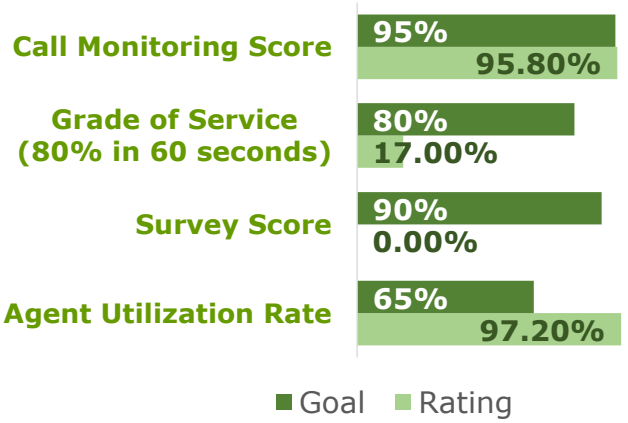
Retiree Healthcare

Total RHC Calls: 7,010



Top Calls

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



Emails 416

Avg. Response Time (ART) 5 Days

Secure Messages 608

Striving for Excellence

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

Disability

Applications 844

In Process As Of 5/31/2022

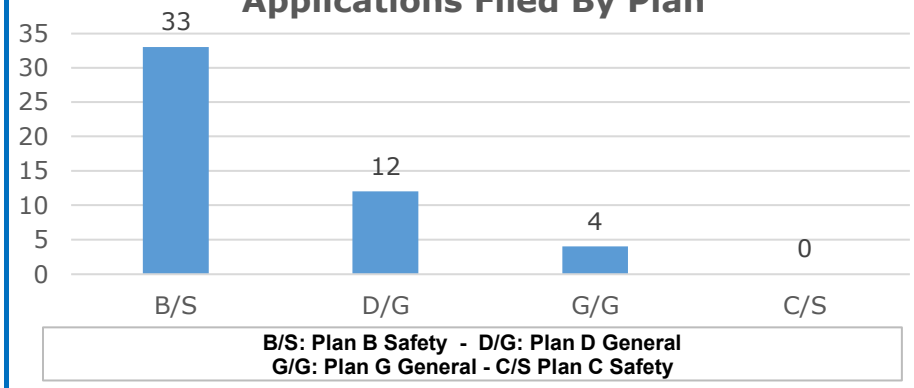
869 Pending on: 4/30/2022
49 Received
699 Year-to-Date
0 Re-Opened
0 Year-to-Date
60 To Board - Initial
529 Year-to-Date
14 Closed
65 Year-to-Date

Appeals 72

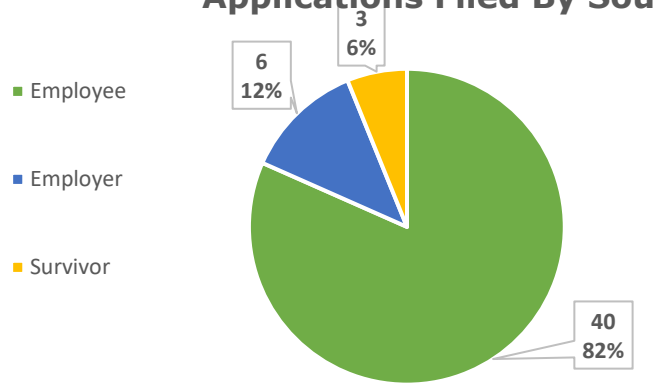
In Process As Of 5/31/2022

68 Pending on: 4/30/2022
6 Received
26 Year-to-Date
2 Admin Closed/Rule 32
28 Year-to-Date
0 Referee Recommended
6 Year-to-Date
0 Revised/Reconsidered for Granti
0 Year-to-Date

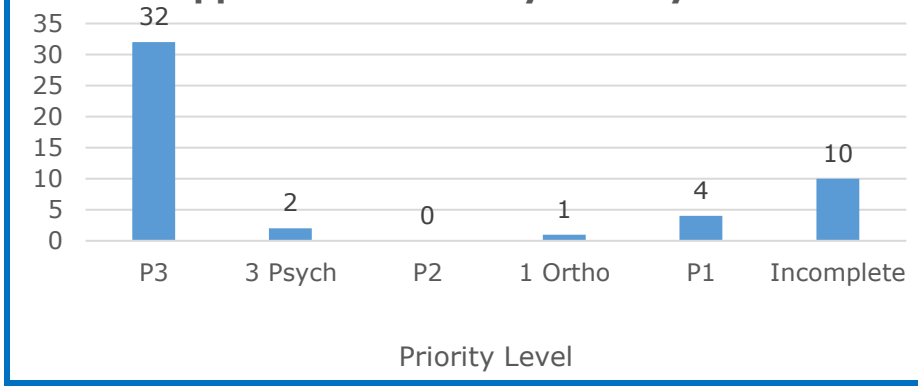
Applications Filed By Plan



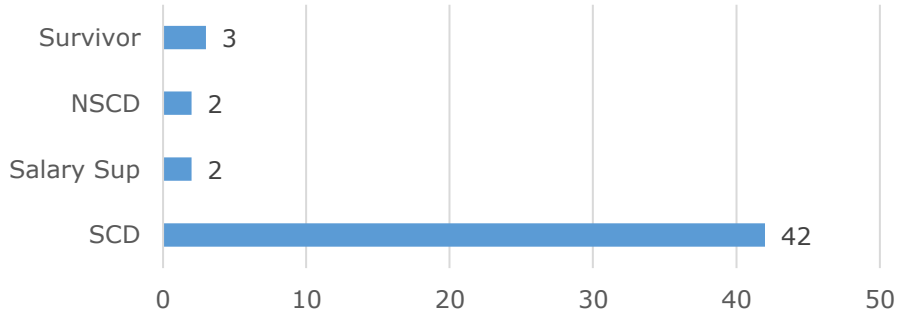
Applications Filed By Source



Applications Filed By Priority Level



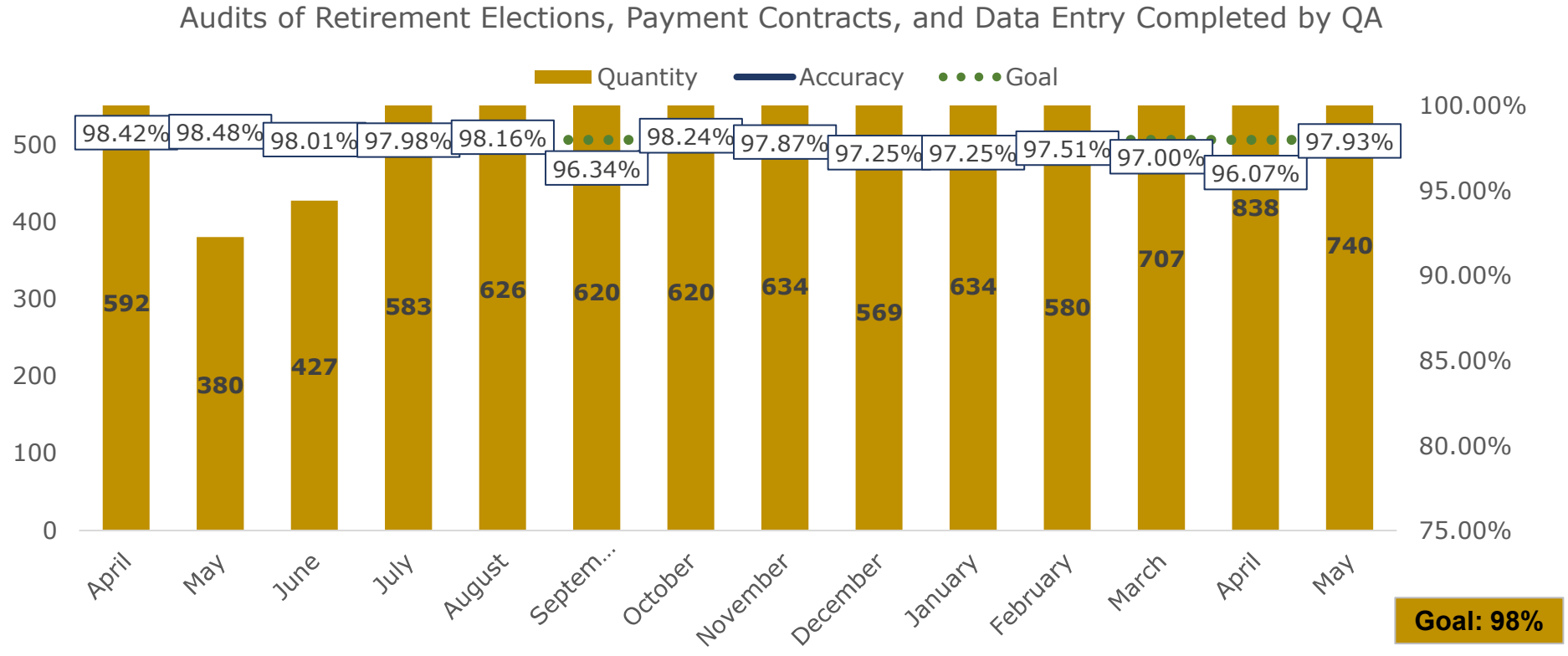
Applications Filed By Type



Striving for Excellence in Quality

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

Quality Assurance



May 2022

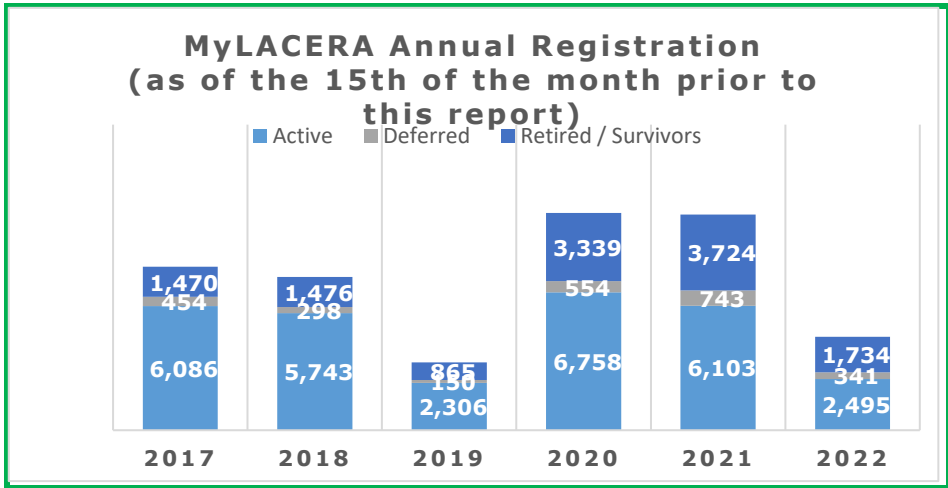
97.93%

Retirement Elections		Payment Contracts		Data Entry	
204	Samples	446	Samples	90	Samples
97.74%	Accuracy	96.05%	Accuracy	100.00%	Accuracy

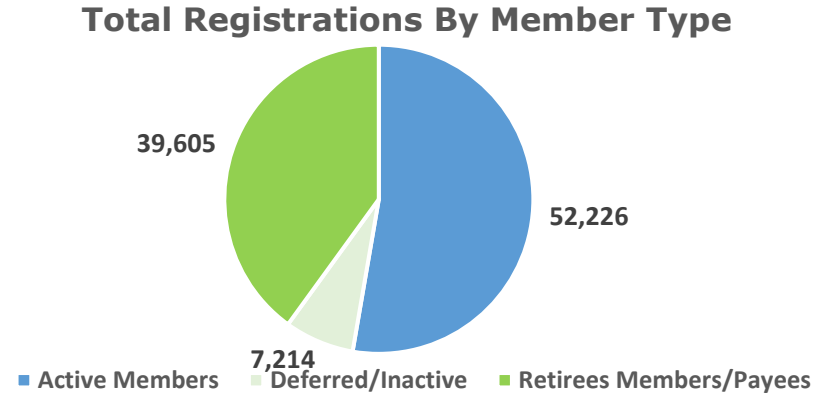
Service On-Line for All

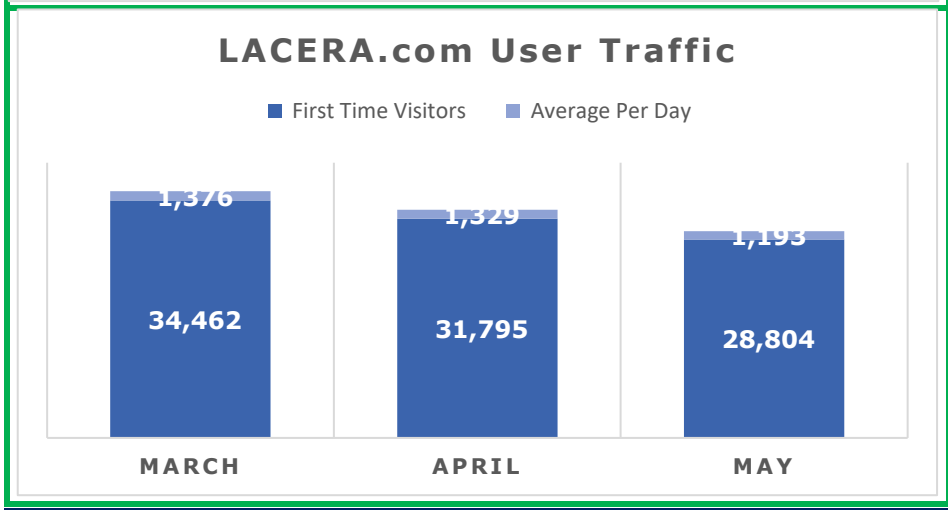
Service Metrics Reported on a Fiscal Year Basis (July 1) Through: May 2022

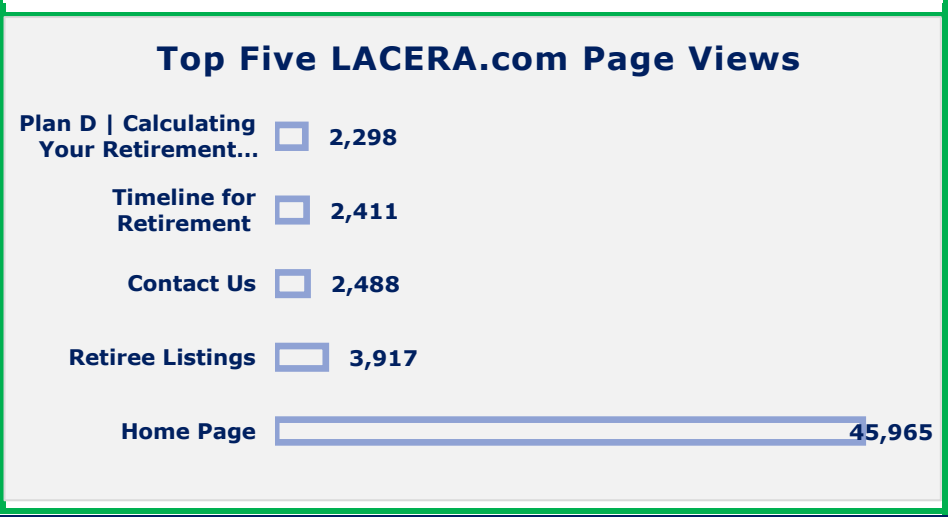
Serving Members Through LACERA.com and MyLACERA



Total Registered Members	99,045	59%







Home Page "I Would Like To" View	Views	% of Change
Print a Payday Calendar	1,322	25%
Update My Beneficiary	1,119	2%
Apply for Survivor Benefits	663	-15%
Change My Tax Settings	947	-35%
View Retirement Timeline	2,411	N/A
Busiest Day of the Month	Thursday, May 26, 2022	

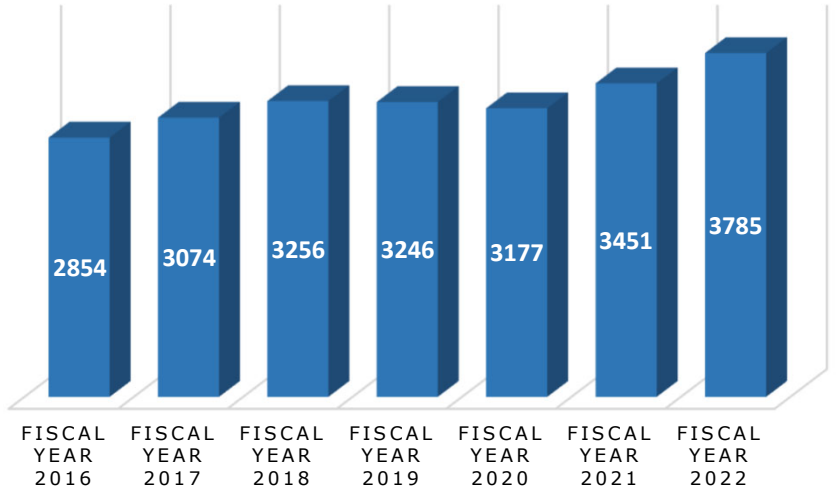
Home Page Tile Views	Views	% of Change
My LACERA	1,969	-28%
Pre-Retirement Workshops	1,023	-8%
Careers	1,185	-1%
Investments	895	18%
Annual Reports	489	-12%
Forms & Publications	189	11%

Member Snapshot

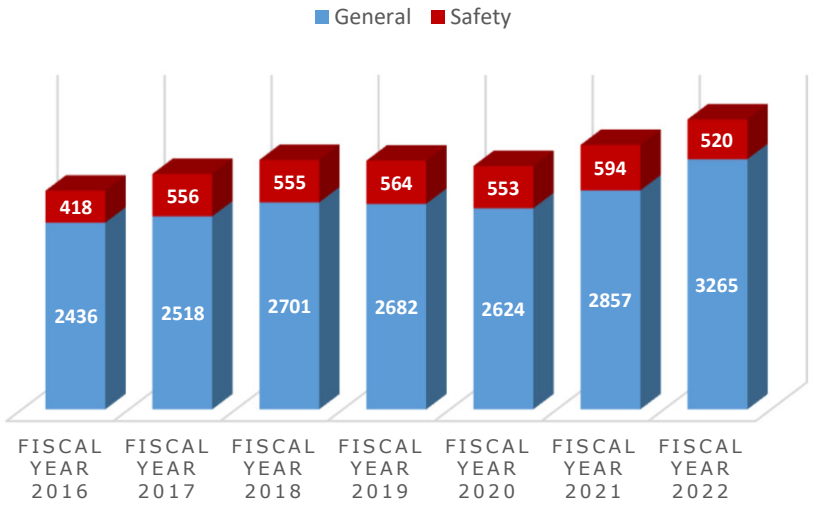
Service Metrics Reported on a Fiscal Year Basis (July 1) Through: May 2022

	Members as of 06/15/2022				
	Plan	Active	Retired	Survivors	Total
General	Plan A	55	13,980	4,155	18,190
	Plan B	15	644	69	728
	Plan C	18	421	65	504
	Plan D	35,898	19,942	1,820	57,660
	Plan E	14,079	14,842	1,514	30,435
	Plan G	33,312	179	13	33,504
	Total General	83,377	50,008	7,636	141,021
Safety	Plan A	1	4,546	1,651	6,198
	Plan B	8,112	7,392	383	15,887
	Plan C	4,718	19	2	4,739
	Total Safety	12,831	11,957	2,036	26,824
TOTAL MEMBERS		96,208	61,965	9,672	167,845
% by Category		57%	37%	6%	100%

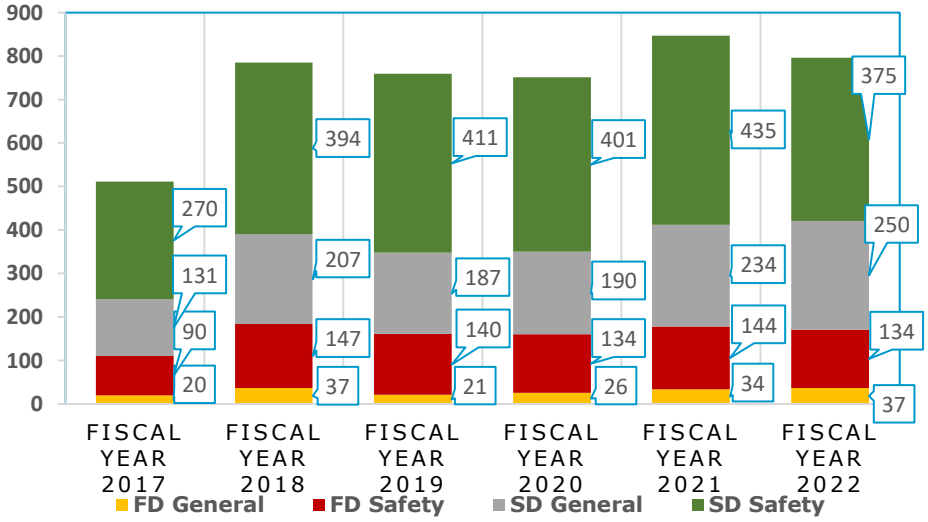
RETIREMENTS BY YEAR



ANNUAL RETIREMENTS BY TYPE



GENERAL VS. SAFETY RETIREMENTS FOR FIRE AND SHERIFF



Member Snapshot

Average Monthly Benefit Allowance Distribution June 23, 2022	General	Safety	Total	%
$0 to $3,999	30,053	1,498	31,551	51.0%
$4,000 to $7,999	14,167	3,451	17,618	28.5%
$8,000 to $11,999	4,040	4,276	8,316	13.4%
$12,000 to $15,999	1,120	2,107	3,227	5.2%
$16,000 to $19,999	368	430	798	1.3%
$20,000 to $23,999	113	138	251	0.4%
$24,000 to $27,999	31	41	72	0.1%
> $28,000	23	4	27	0.0%
Totals	49,915	11,945	61,860	100%

Average Monthly Benefit Amount: $ 4,729.00

Healthcare Program
(Mo. Ending:5/31/2022)

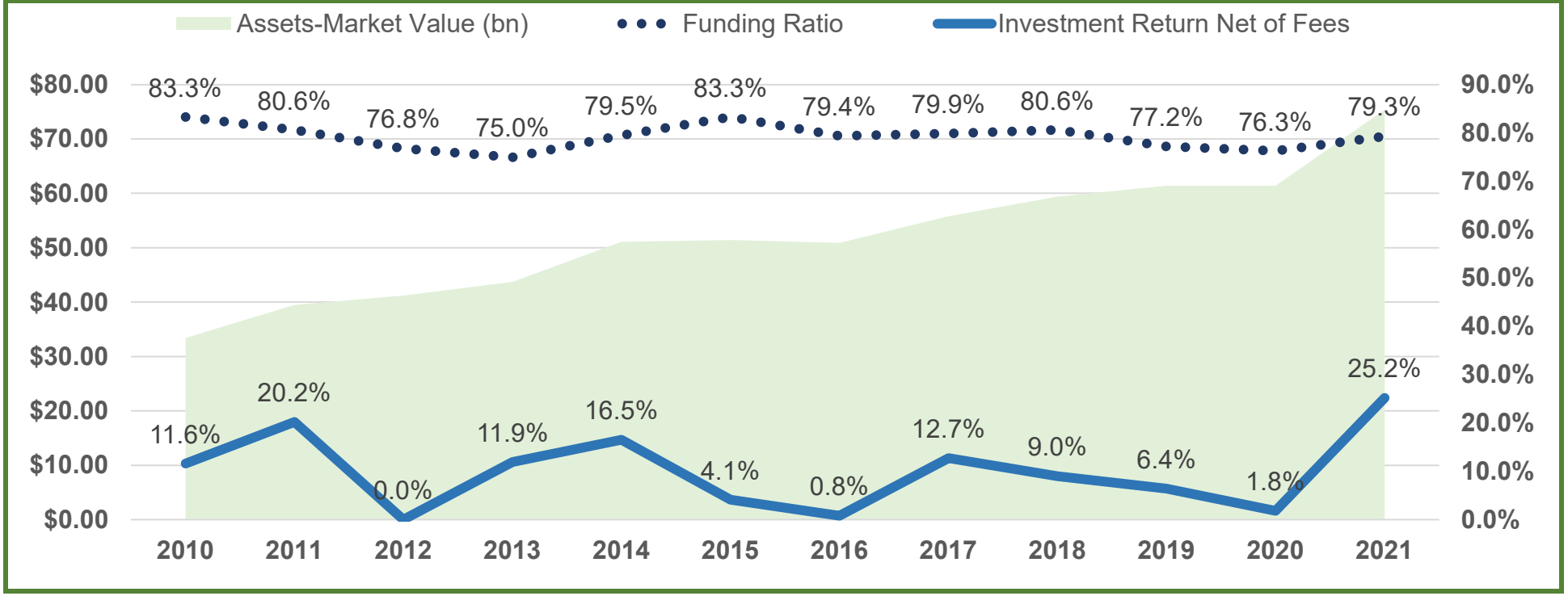
	Employer	Member
Medical	$534.5	$39.6
Dental	$42.6	$4.1
Part B	$75.3	$0.0
Total	**$652.4**	**$43.7**

Health Care Enrollments
(Mo. Ending:5/31/2022)

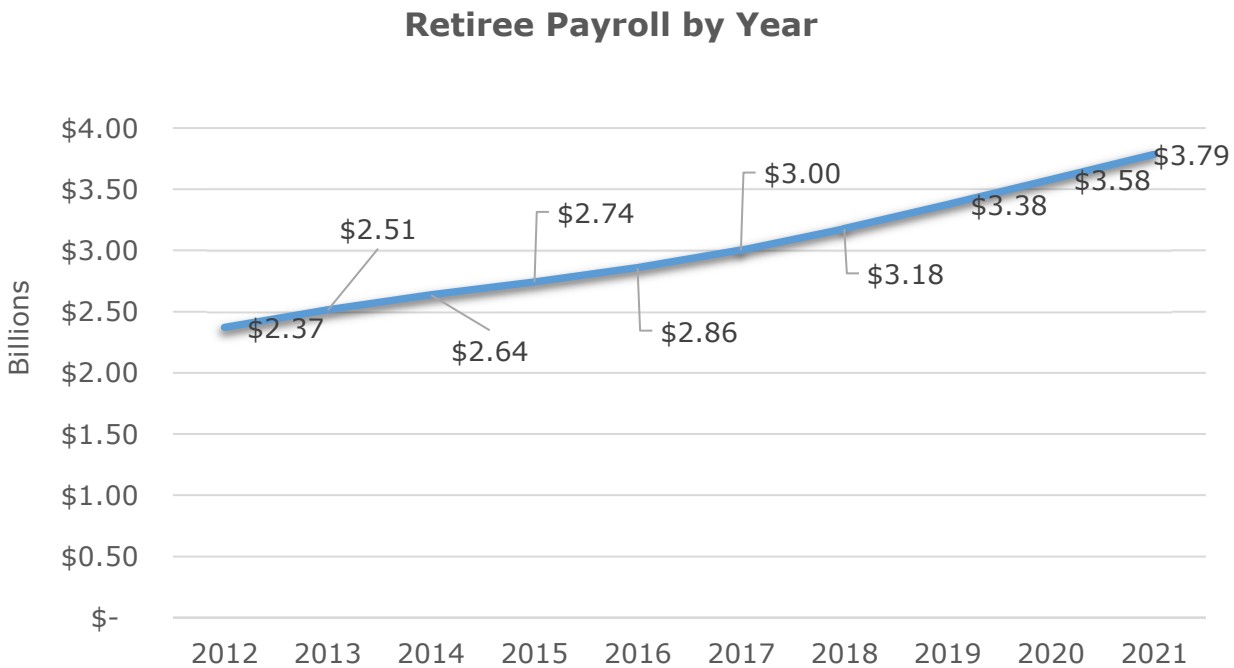
Medical	53,731
Dental	55,447
Part B	36,846
LTC	536
Total	**146,560**

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 5/31/2022)

Monthly Payroll	$353.51m
Payroll YTD	$3.7b
New Retired Payees Added	275
Seamless %	96.00%
New Seamless Payees Added	4,877
Seamless YTD	96.76%
By Check %	2.00%
By Direct Deposit %	98.00%

QUIET PERIOD LIST
Administrative/Operations
Last Update:6/9/2022

RFP/RFI Name	Issuing Division	RFP Issued	Status*	Quiet Period for RFP 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
Contract Lifecycle Management Application	Administrative Services/ Systems	3/4/2022	Vendor Presentation and Evaluation	• Agiloft • Cobblestone • DocuSign • Icertis • Pantheon •
				•
2Case Management Software Solution	Systems Division	10/6/2021	Contract Negotiation	• Eccentex •
Budget Software	Administrative Services/ Systems	3/10/2022	RFP Review	• Neubrain • ClearGov • Workday • Vena • Prophix • Questica • Denovo/Oracle • Board • TruEd/TruGov • IGM/Gravity

RFP/RFI Name	Issuing Division	RFP Issued	Status*	Quiet Period for RFP Respondents*
Executive Recruitment Services	Human Resources	2/23/2022	Bid Review	• Alliance Consulting • David Gomez Partners, Inc • EFL • Ralph Anderson • Spencer Stuart • WBCP
Investments Operational Due Diligence	Internal Audit	5/20/2022	Solicitation Process	• KPMG • Deloitte

*Subject to change

INVESTMENTS QUIET PERIOD FOR SEARCH RESPONDENTS

Custody Bank Search

- ✓ State Street Bank and Trust Co.

Illiquid Credit Emerging Manager Program Search

- ✓ BlackRock Alternative Advisors
- ✓ Blackstone Alternative Asset Management
- ✓ Cambridge Associates
- ✓ GCM Grosvenor
- ✓ Stable Asset Management

OPEB Private Markets Investments Search

- ✓ BlackRock Financial Management Inc.
- ✓ Cambridge Associates LLC
- ✓ Goldman Sachs Asset Management, L.P.
- ✓ Hamilton Lane Advisors, LLC
- ✓ HarbourVest Partners, LLC
- ✓ J.P. Morgan Asset Management
- ✓ Morgan Stanley Investment Management
- ✓ Neuberger Berman Alternatives Advisers, LLC
- ✓ Pathway Capital Management, LP
- ✓ StepStone Group Holdings, LLC

Date	Conference
July, 2022	
13-15	Pacific Pension Institute (PPI) Summer Roundtable Vancouver, British Columbia
17-22	Leading in Artificial Intelligence: Exploring Technology and Policy Harvard Kennedy School, Cambridge, MA
August, 2022	
21-23	NCPERS (National Conference on Public Employee Retirement Systems) Public Pension Funding Forum Los Angeles, CA
29-September 1	CALAPRS (California Association of Public Retirement Systems) Principles of Pension Governance for Trustees Tiburon, CA
September, 2022	
16	CALAPRS (California Association of Public Retirement Systems) Round Table – Benefits Virtual
20-22	Council of Institutional Investors (CII) Fall Conference Boston, MA
October, 2022	
8-11	National Association of Corporate Directors (NACD) Summit 2022 National Harbor, MD *(or virtual)*
9-10	CRCEA (California Retired County Employees Association) Fall Conference Sacramento, CA
10-14	Investment Strategies & Portfolio Management Wharton School, University of Pennsylvania
19-21	PREA (Pension Real Estate Association) Annual Institutional Investor Conference Washington D.C.
19-21	Pacific Pension Institute (PPI) Asia Roundtable Singapore
23-26	NCPERS (National Conference on Public Employee Retirement Systems) Public Safety Conference Nashville, TN
23-26	IFEBP (International Foundation of Employment Benefit Plans) Annual Employee Benefits Conference Las Vegas, NV
28	CALAPRS (California Association of Public Retirement Systems) Round Table – Trustees Virtual

LACERA

Documents not attached are exempt from disclosure under the California Public Records Act and other legal authority.

For further information, contact:
LACERA
Attention: Public Records Act Requests
300 N. Lake Ave., Suite 620
Pasadena, CA 91101

LACERA

June 27, 2022

TO: Each Trustee,
Board of Retirement
Board of Investments

FROM: Steven P. Rice, SPR
Chief Counsel

FOR: July 6, 2022 Board of Retirement Meeting
July 13, 2022 Board of Investments Meeting

SUBJECT: Approval of Teleconference Meetings Under AB 361 and Government Code Section 54953(e)

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 the County of Los Angeles and other agencies still recommend social distancing such that each Board and its Committees shall hold teleconference meetings for the next 30 days, so long as the State of Emergency remains in effect, and 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.

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.

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. It is unclear when the State of Emergency will end, although 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."

The Los Angeles County Department of Public Health maintains guidance to "Keep your distance. Use two arms lengths as your guide (about 6 feet) for social distancing with

people outside your household when you are not sure that they are vaccinated." http://publichealth.lacounty.gov/acd/ncorona2019/reducingrisk/. The County Public Health Department also maintains guidance that employers should, "Whenever possible, take steps to reduce crowding indoors and encourage physical distancing: … Limit indoor occupancy to increase the physical space between employees at the worksite, between employees and customers, and between customers. … Continue, where feasible to offer telework options for employees. Offer teleworking options during times of high community transmission (100 or more new cases per 100,000 persons in the past 7 days). In addition, at other times, consider offering teleworking arrangements that do not interfere with business operations to reduce crowding indoors." http://publichealth.lacounty.gov/acd/ncorona2019/bestpractices/.

As further indication of the County's interpretation of the impact of the State of Emergency on public meetings, at its June 14, 2022 meeting, the Board of Supervisors voted to find that the State of Emergency remains active and "local officials continue to recommend measures to promote social distancing" and that the Board of Supervisors shall continue to hold teleconference meetings under the terms of Assembly Bill 361 and Government Code Section 54953(e)(3). However, on June 24, 2022, the Executive Office of the Board of Supervisors issued a press release announcing that "meetings will remain virtual until the transmission level drops to 'low' and remains at that level for 7 days." The Board of Supervisors will resume meetings in the Board hearing room when this standard is met, although Public Comment will continue to be available telephonically.

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. As of the date of this memo, the City Council continues to hold its meetings by videoconference/teleconference, although some council members have started to attend in person in the council chambers. At its June 20, 2022 meeting, the City Council voted to extend the video and teleconference meeting process through July 20, 2022. It is unclear how long the City Council will continue to hold teleconference meetings.

The Centers for Disease Control and Prevention (CDC) has updated its guidance, but the CDC still advises the public to "Stay 6 feet away from others" and that, "Indoors in public: "If you are not up to date on COVID-19 vaccines, stay at least 6 feet away from other

people, especially if you are at higher risk of getting very sick with COVID-19." https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html#stay6ft%20.

Under these circumstances, the Boards may reasonably conclude and find that teleconferencing under Section 54953(e) is appropriate for Board and Committee meetings 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, as required by the statute. Either finding is sufficient under Section 54953(e) to support continued teleconference meeting.

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.

Finally, while the pandemic continues to present a significant health risk, as the virus presents itself in different variants, LACERA staff returned to the office on May 2, 2022 under hybrid work schedules for most employees, including both on site work and continued teleworking. The return to office for staff is made under COVID safety protocols, including vaccination and testing procedures and encouraging masks and social distancing. When the Boards decide to return to in person meetings, management will develop protocols for the boardroom, which will present separate safety challenges, including, for example, the small size of the room, ingress and egress, and public access and comment requirements.

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 the County of Los Angeles and other agencies still recommend social distancing such that each Board and its Committees shall hold teleconference meetings for the next 30 days, 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.

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c:

Santos H. Kreimann	Luis Lugo	JJ Popowich
Jonathan Grabel	Laura Guglielmo	Carly Ntoya

LACERA

June 28, 2022

TO: Trustees, Board of Retirement

FOR: Board of Retirement Meeting on July 6, 2022

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 JULY 6, 2022

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
DEREK M. BART	L A COUNTY FIRE DEPT Dept.#FR	06-16-2022	33 YRS 06 MOS
FRANK C. BRAVO III	SHERIFF Dept.#SH	06-13-2022	34 YRS 11½ MOS
ERNEST E. CHAVEZ	SHERIFF Dept.#SH	05-31-2022	35 YRS 05½ MOS
IRMA T. CHEVALIER	SHERIFF Dept.#SH	06-30-2022	29 YRS 11 MOS
BRIAN D. ENGLEN	SHERIFF Dept.#SH	05-31-2022	30 YRS 11½ MOS
GARY P. HARRIS	L A COUNTY FIRE DEPT Dept.#FR	06-29-2022	31 YRS 08 MOS
RICHARD L. HIRSCH	SHERIFF Dept.#SH	08-27-2022	31 YRS 04 MOS
DANA E. LIGHT	L A COUNTY FIRE DEPT Dept.#FR	06-30-2022	17 YRS 00 MOS
PATRICK T. LONG	L A COUNTY FIRE DEPT Dept.#FR	07-08-2022	33 YRS 06½ MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ERIC F. PETERSON	L A COUNTY FIRE DEPT Dept.#FR	05-31-2022	27 YRS 05½ MOS
KAREN D. PEWITT	DISTRICT ATTORNEY Dept.#DA	06-30-2022	25 YRS 04 MOS
CHRISTOPHER A. PLANK	L A COUNTY FIRE DEPT Dept.#FR	06-30-2022	33 YRS 08 MOS
ANDREW H. ROSSO	SHERIFF Dept.#SH	06-30-2022	37 YRS 11 MOS
WILLIAM K. WHALEN	L A COUNTY FIRE DEPT Dept.#FR	06-30-2022	33 YRS 03 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ANNA B. AGOSTO ALVAR	SHERIFF Dept.#SH	06-06-2022	44 YRS 06½ MOS
ELVIRA ALVAREZ	AUDITOR - CONTROLLER Dept.#AU	06-15-2022	31 YRS 07½ MOS
MA LOURDES M. AQUINO	AMBULATORY CARE NETWORK Dept.#HN	06-30-2022	17 YRS 10 MOS
FLORENCIA ARELLANO	PUBLIC HEALTH PROGRAM Dept.#PH	05-28-2022	35 YRS 05 MOS
CHRISTOPHER P. AREVALO	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-01-2022	15 YRS 01 MOS
TERESA A. ARMOUR	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	41 YRS 09 MOS
YALEMZERF M. ASFAW	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-01-2022	19 YRS 10 MOS
JAMES BACH	INTERNAL SERVICES Dept.#IS	07-30-2022	16 YRS 00 MOS
JORGE A. BADEL	PARKS AND RECREATION Dept.#PK	07-01-2022	17 YRS 05½ MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
PAUL J. BARBE	PUBLIC WORKS Dept.#PW	05-27-2022	36 YRS 09 MOS
GEORGIA L. BARNES	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-15-2022	26 YRS 02½ MOS
HUGO R. BENITEZ	PUBLIC WORKS Dept.#PW	06-30-2022	20 YRS 00 MOS
NANCY A. BILLIN	CHILDREN & FAMILY SERVICES Dept.#CH	07-16-2022	28 YRS 03 MOS
SUSAN BISHOP	SUPERIOR COURT/COUNTY CLERK Dept.#SC	06-03-2022	24 YRS 02½ MOS
PRISCILLA Z. BOCALIG	PROBATION DEPARTMENT Dept.#PB	06-30-2022	13 YRS 07 MOS
DANTE S. BONDOC	SUPERIOR COURT/COUNTY CLERK Dept.#SC	04-30-2022	27 YRS 10½ MOS
ISAIAS BORRERO	PROBATION DEPARTMENT Dept.#PB	05-28-2022	15 YRS 08 MOS
VALERIE A. BRAGG	PUBLIC HEALTH PROGRAM Dept.#PH	06-30-2022	33 YRS 08 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
CINDY L. BRODY	PUBLIC LIBRARY Dept.#PL	07-30-2022	23 YRS 00 MOS
ERNESTINE BROWN	LACERA Dept.#NL	08-08-2022	20 YRS 03½ MOS
JOSEPH BROWN	BEACHES & HARBORS Dept.#BH	06-30-2022	14 YRS 00 MOS
JAMES E. BURNEY	PROBATION DEPARTMENT Dept.#PB	07-29-2022	22 YRS 00 MOS
ESTHER CALVO	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-13-2022	31 YRS 09½ MOS
TERESA CARDENAS	PROBATION DEPARTMENT Dept.#PB	06-30-2022	34 YRS 09 MOS
ESTELA CARRILLO	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	05-31-2022	22 YRS 07½ MOS
IRVING CARVAJAL	SHERIFF Dept.#SH	06-21-2022	20 YRS 01½ MOS
ROXANA CASTILLO	LACERA Dept.#NL	06-30-2022	24 YRS 05 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
SANDRA E. CHAPMAN	PARKS AND RECREATION Dept.#PK	06-29-2022	16 YRS 07 MOS
PATRICIA A. CHARLTON	PUBLIC DEFENDER Dept.#PD	07-30-2022	37 YRS 02 MOS
JON M. CHATMAN	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	26 YRS 08 MOS
BOB CHEONG	CHILDREN & FAMILY SERVICES Dept.#CH	04-30-2022	02 YRS 10½ MOS
YELENA CHOBANIAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-30-2022	24 YRS 01 MOS
ANDREW CHUANG	PUBLIC WORKS Dept.#PW	06-30-2022	34 YRS 06 MOS
RICARDO C. CIRIA	ASSESSOR Dept.#AS	06-30-2022	30 YRS 05 MOS
RACHEL H. CIVEN	PUBLIC HEALTH PROGRAM Dept.#PH	05-14-2022	28 YRS 01 MOS
LINDA R. CLARK	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	34 YRS 02 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
SHIRMA J. CONLIFFE	SHERIFF Dept.#SH	06-25-2022	32 YRS 00 MOS
PAMELA E. CONTRERAS	AMBULATORY CARE NETWORK Dept.#HN	06-30-2022	24 YRS 07 MOS
DIANA CONTRERAS-BE	DISTRICT ATTORNEY Dept.#DA	06-30-2022	24 YRS 00 MOS
RICHARD H. CRUZ	SHERIFF Dept.#SH	05-31-2022	17 YRS 02½ MOS
SHIRLEY ANN W. DAVIS	CHILDREN & FAMILY SERVICES Dept.#CH	07-30-2022	13 YRS 05 MOS
DIANA DE VILLIERS	SUPERIOR COURT/COUNTY CLERK Dept.#SC	06-06-2022	24 YRS 04½ MOS
YOLANDA DEBACA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	25 YRS 00 MOS
ALEX DEL ROSARIO	AMBULATORY CARE NETWORK Dept.#HN	06-16-2022	33 YRS 03 MOS
KONJIT A. DENBERU	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-15-2022	13 YRS 03½ MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
UDAY DEVGAN	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	08-31-2022	09 YRS 03 MOS
PENPA DHONDUP	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	05-31-2022	40 YRS ½ MOS
TAMARA A. DIAMOND	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	23 YRS 04 MOS
CHAU DO	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-30-2022	23 YRS 02 MOS
JACQUELYN DOMINO	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	05-10-2022	14 YRS 09 MOS
LA ELLAN D. DOUGLAS	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	28 YRS 09 MOS
PENNY DOVAL	SUPERIOR COURT/COUNTY CLERK Dept.#SC	06-15-2022	43 YRS 10 MOS
SANDRA L. ELVIK	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	06-30-2022	37 YRS 05 MOS
LUIS M. ENRIQUEZ	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-02-2022	28 YRS 04½ MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
GRACE M. ESPANA	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	26 YRS 05 MOS
AMAL ESTAFANOUS	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	25 YRS 00 MOS
BELEN M. FABRIGAS	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	06-30-2022	31 YRS 05½ MOS
MARK G. FERGUSON	PUBLIC HEALTH PROGRAM Dept.#PH	07-30-2022	25 YRS 00 MOS
SARA FLAMENCO	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-23-2022	15 YRS 02 MOS
RICHARD FLORES	BEACHES & HARBORS Dept.#BH	06-30-2022	45 YRS 11 MOS
SHIRLEY FLOURNOY	MENTAL HEALTH Dept.#MH	06-30-2022	19 YRS 04 MOS
KARL A. FRANCIS	PUBLIC WORKS Dept.#PW	06-30-2022	14 YRS 11 MOS
LISA M. FREESE	SUPERIOR COURT/COUNTY CLERK Dept.#SC	06-30-2022	25 YRS 06 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
MARILYN P. GALAPON	CORRECTIONAL HEALTH Dept.#HC	06-30-2022	13 YRS 00 MOS
GILBERTO E. GARCIA-TORRE	MENTAL HEALTH Dept.#MH	06-30-2022	06 YRS 02 MOS
GESU GEVORKYAN	SHERIFF Dept.#SH	06-30-2022	16 YRS 07 MOS
JERRY GILCHRIST	INTERNAL SERVICES Dept.#IS	05-10-2022	43 YRS 07½ MOS
LORI S. GLASS SPUNT	AMBULATORY CARE NETWORK Dept.#HN	05-28-2022	22 YRS 05½ MOS
VERNICE M. GODFREY	SHERIFF Dept.#SH	05-31-2022	14 YRS 02½ MOS
JEFFERY L. GRANT	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	21 YRS 10 MOS
JULIA A. GRAVLIN	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-30-2022	33 YRS 07 MOS
MARIA M. GRIGLIO	COUNTY COUNSEL Dept.#CC	06-22-2022	17 YRS 00 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ROSA GUTIERREZ	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-30-2022	20 YRS 02½ MOS
ANDRE K. HARPER	HEALTH SERVICES ADMINISTRATION Dept.#HS	07-01-2022	34 YRS 03½ MOS
PHAN HARRISON	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	06-30-2022	21 YRS 00 MOS
GLEN HARVEY	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	06-30-2022	28 YRS 04 MOS
WILLIAM J. HASCHER	SHERIFF Dept.#SH	07-03-2022	20 YRS 01½ MOS
ELIZABETH HERNANDEZ	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	07-30-2022	16 YRS 00 MOS
LEO G. HERNANDEZ	TREASURER AND TAX COLLECTOR Dept.#TT	06-30-2022	35 YRS 09 MOS
IRENE HINO	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	07-29-2022	16 YRS 00 MOS
SHAREE D. HOLLIS	INTERNAL SERVICES Dept.#IS	06-30-2022	27 YRS 03 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
KAREN N. HOLMES	CHILDREN & FAMILY SERVICES Dept.#CH	06-11-2022	30 YRS 08½ MOS
SHARON V. HOOKER	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	21 YRS 01 MOS
ZENA HORN	PUBLIC HEALTH PROGRAM Dept.#PH	08-31-2022	39 YRS 00 MOS
M. ZORAIDA HUGHES	SUPERIOR COURT/COUNTY CLERK Dept.#SC	07-30-2022	17 YRS 00 MOS
SOOK K. HWANG	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	06-30-2022	36 YRS 01 MOS
ROBERT H. IRVIN JR	MENTAL HEALTH Dept.#MH	06-03-2022	02 YRS 11½ MOS
MEAD B. JACKSON	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-30-2022	61 YRS 08 MOS
ELAINE T. JACKSON	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	30 YRS 07 MOS
ANTONIA JIMENEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	05-21-2022	11 YRS 08 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
HAE J. JIN	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	06-30-2022	33 YRS 09 MOS
ANDREA JONES	MENTAL HEALTH Dept.#MH	07-30-2022	31 YRS 06 MOS
LINDA A. JONES	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	05-28-2022	35 YRS 00 MOS
ALBERTA P. JORDAN	SUPERIOR COURT/COUNTY CLERK Dept.#SC	07-01-2022	25 YRS 11½ MOS
GINA G. KELLY	SUPERIOR COURT/COUNTY CLERK Dept.#SC	06-30-2022	47 YRS 02 MOS
KAREN E. KENT	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-31-2022	33 YRS 04½ MOS
MELINE KESHISHYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-25-2022	28 YRS 04 MOS
ANTHONY S. KIM	AUDITOR - CONTROLLER Dept.#AU	07-20-2022	21 YRS 00 MOS
LILIA LABELLA	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	07-30-2022	05 YRS 02 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
LUCREZIA LAMOS	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	06-30-2022	31 YRS 01 MOS
ERIC A. LARSON	SHERIFF Dept.#SH	07-20-2022	24 YRS 07 MOS
GAIL D. LEW	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	06-30-2022	41 YRS 09 MOS
JOHN T. LI	INTERNAL SERVICES Dept.#IS	06-30-2022	25 YRS 01 MOS
THELMA LOVE	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	34 YRS 04 MOS
RICHARD LUGO	INTERNAL SERVICES Dept.#IS	04-30-2022	39 YRS 04 MOS
NULA LUSPARYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	31 YRS 11 MOS
SUSAN E. MAJICH	SHERIFF Dept.#SH	07-31-2022	06 YRS 01½ MOS
KELLY B. MANNING	SHERIFF Dept.#SH	05-16-2022	10 YRS 08 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
CAROLINA M. MARTINEZ	PROBATION DEPARTMENT Dept.#PB	05-31-2022	37 YRS 10½ MOS
STEPHANIE A. MARTINEZ	SUPERIOR COURT/COUNTY CLERK Dept.#SC	07-30-2022	34 YRS 03 MOS
VIRGINIA MARTINEZ	SHERIFF Dept.#SH	06-30-2022	41 YRS 05 MOS
FELICIA MELOCOTON	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	06-30-2022	19 YRS 06½ MOS
ROSALBA MORALES	SHERIFF Dept.#SH	06-30-2022	27 YRS 09 MOS
CECILY A. MORRIS	CHILDREN & FAMILY SERVICES Dept.#CH	08-28-2022	07 YRS 09 MOS
CHERYL M. MOTEN	SUPERIOR COURT/COUNTY CLERK Dept.#SC	06-30-2022	36 YRS 10 MOS
RANDALL L. MULLINS	MENTAL HEALTH Dept.#MH	07-31-2022	17 YRS ½ MOS
JUAN R. MUNOZ	HEALTH SERVICES ADMINISTRATION Dept.#HS	06-06-2022	38 YRS 04½ MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
WILLIAM E. NASH	INTERNAL SERVICES Dept.#IS	06-30-2022	10 YRS 00 MOS
LUBNA NAZIM	AMBULATORY CARE NETWORK Dept.#HN	06-30-2022	23 YRS 04½ MOS
CINDY NGUYEN	PUBLIC WORKS Dept.#PW	07-31-2022	25 YRS 07 MOS
DUNG M. NGUYEN	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-01-2022	30 YRS 08½ MOS
SANDRA A. NORTON	INTERNAL SERVICES Dept.#IS	06-25-2022	37 YRS 07 MOS
RAUL NUNGARAY	PUBLIC WORKS Dept.#PW	05-12-2022	30 YRS 08½ MOS
ROBERTO OCEGUEDA	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	05-19-2022	14 YRS 08 MOS
MARI OGUMUSHIAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	25 YRS 05 MOS
DALE OISHI-KOCKER	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	47 YRS 05 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
MARINO M. OLYMPIA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	22 YRS 04 MOS
MICHAEL OTTE	INTERNAL SERVICES Dept.#IS	06-02-2022	37 YRS 01½ MOS
ANN PADRON	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-25-2022	45 YRS 01 MOS
ANA G. PAEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-30-2022	17 YRS 05½ MOS
JULIA A. PALOMAREZ	AMBULATORY CARE NETWORK Dept.#HN	05-31-2022	49 YRS 09½ MOS
YOUNG J. PARK	SUPERIOR COURT/COUNTY CLERK Dept.#SC	05-31-2022	12 YRS 08½ MOS
MELODY A. PENIX	BOARD OF SUPERVISORS Dept.#BS	06-30-2022	25 YRS 00 MOS
SANTIAGO PEREZ	PUBLIC WORKS Dept.#PW	07-31-2022	29 YRS 04 MOS
MARIA PEREZ-GONZAL	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	07-30-2022	25 YRS 04 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
JANICE J. PIERCE	COASTAL CLUSTER-HARBOR/UCLA MC Dept.#HH	06-30-2022	08 YRS 04 MOS
NAOMI P. PILANDE	PUBLIC HEALTH PROGRAM Dept.#PH	07-30-2022	19 YRS 06 MOS
LUIS PINGARRON	SHERIFF Dept.#SH	06-30-2022	24 YRS 08 MOS
MARIA M. PROA	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	06-15-2022	20 YRS 01½ MOS
CYNTHIA A. REEVES-PUGH	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	43 YRS 00 MOS
EDGARDO D. REGIDOR	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-25-2022	21 YRS 00 MOS
ARTHUR REYES	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	06-08-2022	36 YRS 08½ MOS
ROSEMARIE T. RIVERA	SUPERIOR COURT/COUNTY CLERK Dept.#SC	06-30-2022	33 YRS 08½ MOS
FRANCHESTER ROBINSON	AMBULATORY CARE NETWORK Dept.#HN	07-30-2022	35 YRS 09 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
RAUL F. ROBLES	PUBLIC WORKS Dept.#PW	06-30-2022	16 YRS 05 MOS
OLIVIA A. RODRIGUEZ	ALTERNATE PUBLIC DEFENDER Dept.#AD	06-03-2022	17 YRS 11½ MOS
MELVA L. ROGERS HAYGO	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	41 YRS 06 MOS
CYNTHIA L. ROWLAND	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	40 YRS 01½ MOS
GUSTAVO B. RUIZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-30-2022	24 YRS 05 MOS
ALEXANDER R. RUIZ	INTERNAL SERVICES Dept.#IS	07-30-2022	22 YRS 10 MOS
THERESA D. RUPEL	CHILDREN & FAMILY SERVICES Dept.#CH	05-16-2022	37 YRS 09 MOS
INEZ M. SANDOVAL	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	37 YRS 00 MOS
GIL MARTIN SAURA	AGRICULTURAL COMM./WTS & MEAS. Dept.#AW	06-15-2022	15 YRS 05½ MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
MARGO J. SELLERS	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	13 YRS 06 MOS
KUMARPAL J. SHAH	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-31-2022	05 YRS 00 MOS
SHARI M. SJOSTROM	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-30-2022	10 YRS 02 MOS
GRETCHEN D. SMITH	PROBATION DEPARTMENT Dept.#PB	06-30-2022	24 YRS 00 MOS
SUSAN M. SMITH	PUBLIC HEALTH PROGRAM Dept.#PH	05-27-2022	17 YRS 00 MOS
MILTON SMITH II	PROBATION DEPARTMENT Dept.#PB	08-06-2022	37 YRS 06½ MOS
ANA T. SOLORZANO	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	06-30-2022	30 YRS 01 MOS
MICHAEL A. SOLOVAY	SHERIFF Dept.#SH	07-01-2022	25 YRS ½ MOS
JANET SPAULDING	CHILD SUPPORT SERVICES Dept.#CD	05-31-2022	25 YRS ½ MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
VERONICA G. STAMBAUGH	SHERIFF Dept.#SH	06-30-2022	40 YRS 09 MOS
TRACEY SURRY	AMBULATORY CARE NETWORK Dept.#HN	06-26-2022	41 YRS 07 MOS
SABRIANA D. SWAFFORD	INTERNAL SERVICES Dept.#IS	06-30-2022	42 YRS 08 MOS
TAMERA E. TARVER	PUBLIC LIBRARY Dept.#PL	07-01-2022	37 YRS 03½ MOS
DONNA R. THOMAS	SHERIFF Dept.#SH	06-11-2022	31 YRS 02½ MOS
PAMELA VAN SUMMERN	MENTAL HEALTH Dept.#MH	06-04-2022	18 YRS 02½ MOS
YEVGENIYA VARTANYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-01-2022	20 YRS 08½ MOS
ROSA M. VAZQUEZ	AMBULATORY CARE NETWORK Dept.#HN	05-27-2022	42 YRS 09 MOS
RUBY H. WANG	PUBLIC WORKS Dept.#PW	06-03-2022	33 YRS 08½ MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT

NAME	DEPARTMENT	RETIRED	SERVICE
TENZIN W. WANGCHUK	CORRECTIONAL HEALTH Dept.#HC	06-30-2022	13 YRS 01 MOS
LISA R. WHITE-EBULE	CHILDREN & FAMILY SERVICES Dept.#CH	06-30-2022	42 YRS 05 MOS
BRIGITTE J. WILSON	PUBLIC WORKS Dept.#PW	07-30-2022	37 YRS 06 MOS
ROBERT A. WILTSE	CHILDREN & FAMILY SERVICES Dept.#CH	05-31-2022	41 YRS 08½ MOS
JOSEPH D. WING	MENTAL HEALTH Dept.#MH	06-13-2022	10 YRS 11 MOS
RUI YANG	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-16-2022	13 YRS 03½ MOS
YOLANDA ZARAGOZA	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-31-2022	22 YRS 03 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL SURVIVOR APPLICATIONS

NAME	DEPARTMENT	RETIRED	SERVICE
TRENT WESTERN	PUBLIC HEALTH PROGRAM Dept.#PH	01-30-2022	25 YRS 09 MOS

HUSBAND of PATRICIA A HUNDT
dec'd on 01-29-2022, Sect. #31781.3

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
EDUARDO GOMEZ	DISTRICT ATTORNEY Dept.#DA	06-07-2022	02 YRS 03 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
JOHN ALBERINI	PUBLIC WORKS Dept.#PW	06-13-2022	16 YRS 11 MOS
ARMANDO BALDERRAMA	HEALTH PLAN ADMINISTRATION Dept.#HP	06-04-2022	30 YRS 05 MOS
BERNARDO R. BAYLOSIS	AMBULATORY CARE NETWORK Dept.#HN	04-25-2022	09 YRS 01½ MOS
JEFFREY BELL	OFFICE OF PUBLIC SAFETY Dept.#SY	06-30-2022	13 YRS 00 MOS
MARTHA M. BELTRAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-03-2022	32 YRS 03 MOS
CHERYL D. BINGHAM	SHERIFF Dept.#SH	02-01-2022	01 YRS 00 MOS
ROSE S. CHASE	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	05-04-2022	14 YRS 06 MOS
EUGENE CRAWSHAW	DISTRICT ATTORNEY Dept.#DA	05-03-2022	11 YRS 06 MOS
RAFAEL GULKAROV	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	05-10-2022	21 YRS 00 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
BLANCA E. HENRIQUEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	03-21-2022	24 YRS 00 MOS
NANCY C. HERALDEZ	SUPERIOR COURT/COUNTY CLERK Dept.#SC	05-02-2022	10 YRS 09 MOS
MURLINE HOLMES	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	05-31-2022	24 YRS 00 MOS
SILVIA B. IZAGUIRRE	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	03-14-2022	12 YRS 01 MOS
KATHLEEN S. JOHNSON	CHILD SUPPORT SERVICES Dept.#CD	05-28-2022	03 YRS 03 MOS
BETTY J. LARRY	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	05-23-2022	41 YRS 01 MOS
IVY LATIMORE	CHILDREN & FAMILY SERVICES Dept.#CH	06-15-2022	11 YRS 11 MOS
SONIA E. LOPEZ	INTERNAL SERVICES Dept.#IS	05-13-2022	20 YRS ½ MOS
YOLANDE E. LOVELACE	DISTRICT ATTORNEY Dept.#DA	05-14-2022	06 YRS 11 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
THU HA MCLEOD	SUPERIOR COURT/COUNTY CLERK Dept.#SC	05-14-2022	21 YRS 00 MOS
OSA S. OGBEIWI	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	05-24-2022	20 YRS 03 MOS
ANGELA R. PHILLIPS	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	05-14-2022	20 YRS 11 MOS
SUZANNE P. PORRAZZO	DISTRICT ATTORNEY Dept.#DA	06-07-2022	24 YRS 10½ MOS
JANE RINCON	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	06-01-2022	10 YRS 04 MOS
FRANCISCA A. ROCAMORA	TREASURER AND TAX COLLECTOR Dept.#TT	07-16-2021	00 YRS 10 MOS
MARGARITA SANTISTEVAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	03-25-2022	03 YRS 05 MOS
MARTHA SAUERMAN	SUPERIOR COURT/COUNTY CLERK Dept.#SC	06-29-2022	16 YRS 07 MOS
PHANTAZIA Y. SPEARS	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	05-06-2022	13 YRS 06 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
LESLIE L. STOKES	SHERIFF Dept.#SH	06-12-2022	24 YRS 01 MOS
JEROME O. SYKES	RANCHO LOS AMIGOS HOSPITAL Dept.#HR	06-17-2022	10 YRS 03 MOS
AKEMI A. TAKEMOTO	ASSESSOR Dept.#AS	06-27-2022	18 YRS 01 MOS
LEE W. TSAO	SUPERIOR COURT/COUNTY CLERK Dept.#SC	05-05-2022	16 YRS 03½ MOS
NERISSA A. UMALI	NORTHEAST CLUSTER (LAC+USC) Dept.#HG	05-11-2022	12 YRS 07 MOS
L. P. VARELA	SUPERIOR COURT/COUNTY CLERK Dept.#SC	06-10-2022	02 YRS 09 MOS
LUCIE VU	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	07-19-2022	32 YRS 10 MOS
MARLON L. WATERS	PROBATION DEPARTMENT Dept.#PB	06-21-2022	36 YRS 02 MOS
CANELLA S. WELCH	SUPERIOR COURT/COUNTY CLERK Dept.#SC	05-11-2022	13 YRS 08 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIREMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
KATHIE YEHLE	DEPT OF PUBLIC SOCIAL SERVICES Dept.#SS	06-03-2022	12 YRS 11 MOS
SAMSON YIGEZU	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.#HO	05-24-2022	16 YRS 02 MOS

BOARD OF RETIREMENT MEETING OF JULY 6, 2022
RESCISSIONS/CHANGES FROM BENEFIT APPROVAL LIST
APPROVED ON JUNE 1, 2022

SAFETY MEMBER APPLICATIONS FOR SERVICE RETIREMENT

NAME	DEPARTMENT	UPDATE
JEFFREY M HORN	L A COUNTY FIRE DEPT	CHANGE OF DATE TO July 5, 2022

GENERAL MEMBER APPLICATIONS FOR SERVICE RETIREMENT

NAME	DEPARTMENT	UPDATE
RICHARD J HAHN	AMBULATORY CARE NETWORK	CHANGE OF DATE TO April 22, 2020
ROWENA G LABAO	COASTAL CLUSTER-HARBOR/UCLA MC	CHANGE OF DATE TO July 2, 2022
DORIS D AVILES	NORTHEAST CLUSTER (LAC+USC)	CHANGE OF DATE TO July 30, 2022
MARIA ARRIZON	NORTHEAST CLUSTER (LAC+USC)	RESCINDED RETIREMENT
SEYFOLLAH SHARGHI	DEPT OF PUBLIC SOCIAL SERVICES	CHANGE OF DATE TO May 28, 2022
ELIRIA RECIO	NORTHEAST CLUSTER (LAC+USC)	CHANGE OF DATE TO June 1, 2022
LISA I CHAVEZ	AMBULATORY CARE NETWORK	CHANGE OF DATE TO June 1, 2022
DANILO M MIGUEL	SFV CLUSTER-OLIVE VIEW/UCLA MC	CHANGE OF DATE TO May 7, 2022
KIM GEORGE	SUPERIOR COURT/COUNTY CLERK	CHANGE OF DATE TO June 30, 2022
ANNA M COLLAY	LACERA	CHANGE OF DATE TO July 22, 2022
LINDA T LIU	INTERNAL SERVICES	RESCINDED RETIREMENT

LACERA

June 22, 2022

TO: Each Trustee
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: July 6, 2022 Board of Retirement Meeting

SUBJECT: **Assembly Bill 2493—County Employees' Retirement**

Author: *Chen [R]*
Sponsor: *Association of Orange County Deputy Sheriffs*
California Professional Firefighters
Amended: *April 5, 2022*
Introduced: *February 17, 2022*
Status: *From SENATE Committee on LABOR, PUBLIC EMPLOYEMNT AND RETIREMENT: Do pass to Committee on JUDICIARY. (06/22/2022)*

IBLC Recommendation: *Neutral (06/01/2022)*
Staff Recommendation: *Neutral*

RECOMMENDATION
That the Board of Retirement adopt a "Neutral" position on Assembly Bill 2493, which would provide adjustments to retirement payments based on disallowed compensation.

LEGISLATIVE POLICY STANDARD
AB 2493 is not consistent with any of the Board of Retirement's (BOR) legislative policy standards that would entail support or opposition. A "Neutral" position indicates that the proposal affects LACERA and its stakeholders, but the Board neither supports nor opposes it.

SUMMARY
AB 2493 would authorize a county retirement system to adjust retirement allowances based on disallowed compensation for peace officers and firefighters of the system (i.e., safety members). Specifically, the bill would—

- Define "disallowed compensation" as compensation that the retirement system determines is not in compliance with the California Public Employees' Pension Reform Act of 2013 (PEPRA) or the retirement system's administrative regulations.

- Require the employer to discontinue reporting the disallowed compensation as determined by the retirement system. This requirement also applies to determinations made on or after July 30, 2020, if the applicable members or survivors have not exhausted their administrative or legal remedies.
- Provide that for active safety members, employer contributions on the disallowed compensation must be credited to the employer, and member contributions on the disallowed compensation must be returned to the member.
- Provide that for retired safety members and survivors whose final compensation was based on disallowed compensation, the employer contributions on the disallowed compensation must be credited to the employer, and the retirement system must permanently adjust the benefit to reflect the exclusion of the disallowed compensation.
- Provide repayment and notice requirements to retired safety members and survivors whose final compensation was based on disallowed compensation if the following conditions are met:
    - The compensation and contributions were reported to the retirement system while the safety member was actively employed.
    - The compensation was agreed to in a memorandum of understanding or collective bargaining agreement between the employer and a recognized employee organization as compensation for pension purposes, and they did not knowingly agree to disallowed compensation.
    - The retirement system determined that the compensation was disallowed after the date of retirement.
    - The safety member was not aware that the compensation was disallowed at the time it was reported.
- Require the employer that reported the contributions on the disallowed compensation to do the following, if the above conditions are met:
    - Pay to the retirement system the full cost of any overpayment made to a retired safety member or survivor because of the disallowed compensation.
    - Pay a penalty to the retired safety member or survivor equal to 20 percent of a lump sum calculated as the actuarial equivalent of the difference between the monthly allowance based on the disallowed compensation and the adjusted monthly allowance not based on the disallowed compensation for the duration that the adjusted allowance is projected to be paid to the retired safety member or survivor.
    - One hundred percent of the penalty shall be paid by the employer as restitution to the retired safety member or survivor impacted by the disallowed compensation.

- Require the retirement system to provide to the employer and affected retired safety member or survivor notice of the overpayment, actuarial equivalent present value, and obligations of the employer.
- Require the retirement system to provide to the employer the contact information for the retired safety members and survivors, so that the employer can fulfill its obligations on the disallowed compensation. The employer shall keep the contact information confidential.
- Provide that the employer may submit to the retirement system for review compensation items proposed for inclusion in a memorandum of understanding or collective bargaining agreement that are intended for pension benefit calculations. The retirement system would review the compensation item for consistency with PEPRA or its administrative regulations.
    - The compensation items submitted for review shall conform with criteria specified in the California Code of Regulations related to special compensation items and pensionable compensation.
    - The retirement system has 90 days after receipt of all information to make a review to provide guidance on the compensation item.

ANALYSIS

Existing Law

Government Code Section 31460 provides the definition of "compensation," and Section 31461 provides the definition of "compensation earnable." A member's retirement allowance is based on compensation earnable, service credit, and an age factor. Generally, the higher each of these components are, the higher the retirement benefit. A member receives base salary as compensation and may be receiving additional pay items of compensation such as bonuses and buybacks. To the extent that compensation is compensation earnable, it is used in the benefit formula to calculate a retirement allowance.

Beginning in 1997 (due to litigation initiated by an employee organization in the County of Ventura), compensation earnable has expanded to include many pay items in addition to base salary, although the *Ventura*[1] decision also excluded items such as termination pay. In the wake of the *Ventura* decision, several lawsuits were filed statewide by county employees and retirees as to whether *Ventura* should be applied retroactively. Those lawsuits were consolidated into a single proceeding[2] for those retirement systems that did not enter into settlement agreements. Until 2013, the decisions in *Ventura* and *In re Ret. Cases* guided the treatment of compensation earnable in the retirement systems operating under the County Employees Retirement Law of 1937 (CERL).

[1] *Ventura County Deputy Sheriffs' Assn. v. Board of Retirement* (1997) 16 Cal.4th 483
[2] *In re Ret. Cases. Eight Coordinated Cases* (2003) 110 Cal.App.4th 426

PEPRA was enacted to implement then-Governor Jerry Brown's *Twelve Point Pension Reform Plan*. PEPRA generally applies to new employees on or after January 1, 2013 and introduced the definition of "pensionable compensation" for the purposes of calculating a retirement allowance for PEPRA members.

However, the bill (AB 340, Chapter 296, Statutes of 2012) that added PEPRA to the Government Code also amended Section 31461, which provides the definition of "compensation earnable" for legacy members (i.e., those who are not PEPRA members), and sought to limit or exclude certain items of compensation earnable. This change by PEPRA to Section 31461 is also known as the "PEPRA amendment," and litigation on this amendment was initiated in the Counties of Alameda, Contra Costa, and Merced by employee organizations. The litigation culminated in the California Supreme Court's *Alameda*[3] decision on July 30, 2020, which analyzes whether prior settlement agreements (such as those resulting from the *Ventura County* decision) enabled retirement systems to continue to implement them in the face of subsequent contrary legislative changes and the extent to which such legislative changes to a pension plan (such as those relating to compensation earnable) are constitutionally permissible.

This Bill

Although AB 2493 in general requires that a county employer must discontinue reporting compensation that has been determined to be disallowed compensation, the bill also applies to determinations of disallowed compensation made on or after July 30, 2020, the effective date of the *Alameda* decision, if an active or retired safety member or survivor has filed an appeal and not exhausted their administrative or legal remedies.

On March 3, 2021, the BOR determined that Standby Pay, a legacy pay item, was included in the calculation of final compensation and must be excluded as a result of the *Alameda* decision. Therefore, since January 1, 2013, the effective date of PEPRA, members who received Standby Pay made contributions on the pay item and had the item included in final compensation for the calculation of retirement benefits. The BOR adopted a resolution to implement and comply with *Alameda* with respect to Standby Pay and instructed staff to coordinate with the County of Los Angeles to establish the necessary reporting mechanism and procedures to permit LACERA to exclude Standby Pay in the calculation of final compensation.

As reported in the monthly Operations Briefing to the Operations Oversight Committee, LACERA is in the midst of a project to make adjustments for active and retired members who received Standby Pay. Active members who received Standby Pay have ceased making contributions on Standby Pay and are credited with any overpaid contributions. Retired members who had Standby Pay included in final compensation received overpaid retirement allowances as well as made overpaid contributions on the item.

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[3] *Alameda County Deputy Sheriff's Assn. v. Alameda County Employees' Retirement Assn.* (2020) 9 Cal.5th 1032

If enacted, AB 2493 would affect primarily retired safety members who received Standby Pay, made contributions on the item, and had the item included in final compensation. For these members and survivors, any overpayments that occurred before the adjustment of the retirement allowance would be paid by the employer to LACERA rather than by the retired member or survivor. Additionally, the employer would pay a penalty to the member or survivor based on the actuarial present value of the difference in the monthly allowance as a result of excluding Standby Pay from final compensation.

Other Background
The State Association of County Retirement Systems Legislative Committee is monitoring the bill and has not taken a position on it but is providing technical input about the administrative aspects of the bill. The California State Association of Counties has sent an opposition letter to Assemblyman Chen, the author of AB 2493. Staff understands that some of the larger individual CERL counties impacted by the bill are reviewing it and are working on a joint letter.

IT IS THEREFORE RECOMMENDED THAT THE BOARD adopt a "Neutral" position on Assembly Bill 2493, which would provide adjustments to retirement payments based on disallowed compensation.

Attachments
Attachment 1—Board Positions Adopted on Related Legislation
Attachment 2—Support and Opposition
AB 2493 (Chen) as amended on April 5, 2022
CSAC opposition letter dated May 19, 2022

cc: Santos H. Kreimann
Luis Lugo
JJ Popowich
Laura Guglielmo
Steven P. Rice
Fern Billingy
Carlos Barrios
Allan Cochran
Shari McHugh, McHugh Koepke & Associates
Naomi Padron, McHugh Koepke & Associates

BOARD POSITIONS ADOPTED ON RELATED LEGISLATION

AB 826 (Irwin, 2021) would provide that compensation and compensation earnable include flexible benefits plan allowances paid by the county on behalf of its employees as part of a cafeteria plan, if certain requirements are met. The Board of Retirement adopted a "Watch" position.

AB 197 (Chapter 297, Statutes of 2012) enacted technical clarifications to the definition of compensation earnable that was amended by AB 340. The Board of Retirement did not adopt a position.

AB 340 (Chapter 296, Statutes of 2012) enacted the California Public Employees' Pension Reform Act of 2013, amended the County Employees Retirement Law of 1937's (CERL) provisions on compensation earnable, and added new provisions to CERL on the assessment, reporting, and audit of compensation items. The Board of Retirement adopted a "Watch" position.

SUPPORT
Association of Orange County Sheriff's Department (Co-Sponsor)
California Professional Firefighters (Co-Sponsor)
Barstow Professional Firefighters Association Local 2325
California Fraternal Order of Police
Contra Costa County Professional Firefighters Local 1230
Kern County Firefighters Local 1301 Union
Lathrop-Manteca Firefighters Local 4317
Long Beach Police Officers Association
Marin Professional Firefighters Local 1775
Orange County Professional Firefighters Association, Local 3631
Peace Officers Research Association of California (PORAC)
Sacramento County Deputy Sheriffs' Association
San Bernardino County Firefighters Local 965
San Bernardino County Safety Employees' Benefit Association
San Bernardino County Sheriff's Employees' Benefit Association
Ventura County Professional Firefighters Association Local 1364

OPPOSITION
California Special Districts Association
California State Association of Counties
Rural County Representatives of California
Santa Barbara County
San Bernardino County Employees' Retirement Association
San Joaquin County
Urban Counties of California

AMENDED IN ASSEMBLY APRIL 5, 2022

AMENDED IN ASSEMBLY MARCH 24, 2022

CALIFORNIA LEGISLATURE—2021–22 REGULAR SESSION

ASSEMBLY BILL No. 2493

Introduced by Assembly Member Chen

February 17, 2022

An act to~~add~~ Section ~~31639.96~~ *31541.2* to the Government Code, relating to county employees' retirement.

LEGISLATIVE COUNSEL'S DIGEST

AB 2493, as amended, Chen. County employees' retirement: ~~Orange County:~~ disallowed compensation: benefit adjustments.

(1) ~~The~~ *Existing law, the* California Public Employees' Pension Reform Act of 2013 ~~(PEPRA)~~ *(PEPRA)*, generally requires a public retirement system, as defined, to modify its plan or plans to comply with the act. PEPRA, among other things, establishes new defined benefit formulas and caps on pensionable compensation.

The County Employees Retirement Law of 1937 (CERL) authorizes counties to establish retirement systems pursuant to its provisions in order to provide pension benefits to their employees. *CERL generally vests management of each retirement system in a board of retirement.* CERL authorizes a ~~county retirement system in Los Angeles County to adjust retirement payments due to errors or omissions, as specified.~~ *board of retirement to correct errors in the calculation of a retired member's monthly allowances or other benefits under CERL in certain circumstances, including if the member caused their final compensation to be improperly increased or otherwise overstated at the time of retirement and the system applied that overstated amount as the basis*

for calculating the member's monthly retirement allowance or benefits under CERL, subject to certain limitations.

The Public Employees' Retirement Law (PERL) also authorizes its board of administration to adjust retirement payments due to errors or omissions, including for cases in which the retirement systems that the benefits of a member or annuitant are, or would be, based on disallowed compensation that conflicts with PEPRA and other specified laws and is thus impermissible.

This bill would similarly authorize a county retirement system ~~in Orange County~~ to adjust retirement payments based on disallowed compensation for sworn peace officers and firefighters of that system. The bill would provide that if the retirement system determines that the compensation reported for a sworn peace officer or firefighter of the system is disallowed compensation, as defined, the system would require the county employer or agency to discontinue reporting the disallowed compensation. The bill would apply this to determinations made on or after July 30, 2020, if an appeal has been filed and the applicable member, retired member, survivor, or beneficiary has not exhausted their administrative or legal remedies. The bill would require, for an active sworn peace officer or firefighter, that all contribution made on the disallowed compensation be credited against future contributions to the benefit of the employer or agency that reported the disallowed compensation, and any contribution paid by, or on behalf of, that member, be returned to the member by the employer or agency, as specified. The bill would require, for a retired sworn peace officer or firefighter, survivor, or beneficiary whose final compensation was predicated upon the disallowed compensation, that contributions made on the disallowed compensation be credited against future contributions to the benefit of the employer or agency that reported the disallowed compensation and would require the system to permanently adjust the benefit of the affected retired member, survivor, or beneficiary to reflect the exclusion of the disallowed compensation. The bill would specify other conditions required to be satisfied with respect to a retired sworn peace officer or firefighter, survivor, or beneficiary whose final compensation was predicated upon disallowed compensation, including, among others, requiring payment of a penalty by the employer or agency that reported contributions on the disallowed compensation. The bill would also require certain information regarding the relevant retired member, survivor, or beneficiary needed for purposes of these provisions to be kept confidential by the recipient.

(2) 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.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

~~SECTION 1. Section 31639.96 is added to the Government Code, to read:~~

~~31639.96. (a) This section shall only apply to Orange County. The~~

SECTION 1. Section 31541.2 is added to the Government Code, to read:

31541.2. (a) The board of retirement ~~and~~ *or* board of ~~supervisors~~ *supervisors, as authorized pursuant to this chapter,* may enter into any agreements as may be necessary and appropriate to carry out the provisions of this section.

(b) For purposes of this section, "disallowed compensation" means compensation reported for a sworn peace officer or firefighter of the retirement system that the system subsequently determines is not in compliance with the California Public Employees' Pension Reform Act of 2013 (Article 4 (commencing with Section 7522) of Chapter 21 of Division 7 of Title 1), Section 31461, or administrative regulations of the retirement system, through no fault of the sworn peace officer or firefighter.

(c) If the retirement system determines that the compensation reported for a sworn peace officer or firefighter of the system is disallowed compensation, the system shall require the county employer or agency to discontinue reporting the disallowed compensation. This section shall also apply to determinations made on or after July 30, 2020, if an appeal has been filed and the sworn peace officer or firefighter, the retired sworn peace officer or firefighter, survivor, or beneficiary has not exhausted their administrative or legal remedies.

(1) In the case of an active sworn peace officer or firefighter, all contributions made on the disallowed compensation shall be

credited against future contributions to the benefit of the employer or agency that reported the disallowed compensation, and any contribution paid by, or on behalf of, that member, shall be returned to the member by the employer or agency that reported the disallowed compensation.

(2) In the case of a retired sworn peace officer or firefighter, survivor, or beneficiary whose final compensation at the time of retirement was predicated upon the disallowed compensation, the contributions made on the disallowed compensation shall be credited against future contributions, to the benefit of the employer or agency that reported the disallowed compensation and the system shall permanently adjust the benefit of the affected retired member, survivor, or beneficiary to reflect the exclusion of the disallowed compensation.

(3) (A) In the case of a retired sworn peace officer or firefighter, survivor, or beneficiary whose final compensation at the time of retirement was predicated upon the disallowed compensation as described in paragraph (2), the repayment and notice requirements described in this paragraph and paragraph (4) shall apply only if all of the following conditions are met:

(i) The compensation was reported to the system and contributions were made on that compensation while the sworn peace officer or firefighter was actively employed.

(ii) The compensation was agreed to in a memorandum of understanding or collective bargaining agreement between the employer and the recognized employee organization as compensation for pension purposes and the employer and the recognized employee organization did not knowingly agree to compensation that was disallowed.

(iii) The determination by the system that compensation was disallowed was made after the date of retirement.

(iv) The sworn peace officer or firefighter was not aware that the compensation was disallowed at the time it was reported.

(B) If the conditions of subparagraph (A) are met, the employer or agency that reported contributions on the disallowed compensation shall do all of the following:

(i) Pay to the system, as a direct payment, the full cost of any overpayment of the prior paid benefit made to an affected retired member, survivor, or beneficiary resulting from the disallowed compensation.

(ii) Pay a penalty, as described in clause (iii), equal to 20 percent of the amount calculated as a lump sum of the actuarial equivalent present value representing the difference between the monthly allowance that was based on the disallowed compensation and the adjusted monthly allowance calculated pursuant to paragraph (2) for the duration that allowance is projected to be paid by the system to the retired member, survivor, or beneficiary.

(iii) One hundred percent of the penalty to be paid under clause (ii) shall be paid by the employer or agency as restitution to the affected retired member, survivor, or beneficiary who was impacted by disallowed compensation.

(4) The system shall provide a notice to the employer or agency that reported contributions on the disallowed compensation and to the affected retired member, survivor, or beneficiary, including, at a minimum, all of the following:

(A) The amount of the overpayment to be paid by the employer or agency to the system as described in subparagraph (B) of paragraph (3).

(B) The actuarial equivalent present value owed to the retired member, survivor, or beneficiary as described in clause (ii) of subparagraph (B) of paragraph (3), if applicable.

(C) Written disclosure of the employer or agency's obligations to the retired member, survivor, or beneficiary pursuant to this section.

(5) The system shall, upon request, provide the employer or agency with contact information data in its possession of a relevant retired member, survivor, or beneficiary in order for the employer or agency to fulfill their obligations to that retired member, survivor, or beneficiary pursuant to this section. The recipient of this contact information data shall keep it confidential.

(d) (1) The employer or agency, as applicable, may submit to the system for review an additional compensation item that is proposed to be included, or is contained, in a memorandum of understanding adopted, or a collective bargaining agreement entered into, on and after January 1, 2022, that is intended to form the basis of a pension benefit calculation, in order for the system to review consistency of the proposal with the California Public Employees' Pension Reform Act of 2013 (Article 4 (commencing with Section 7522) of Chapter 21 of Division 7 of Title 1), Section

31461, the retirement system, and the administrative regulations of the system.

(2) A submission to the system for review under paragraph (1) shall include only the compensation item language and a description of how it meets the criteria listed in subdivision (a) of Section 571 or subdivision (b) of Section 571.1 of Title 2 of the California Code of Regulations, along with any other supporting documents or requirements the system deems necessary to complete its review.

(3) The system shall provide guidance regarding the submission within 90 days of the receipt of all information required to make a review.

(e) The system shall periodically publish a notice of the proposed compensation language submitted to the system pursuant to this section for review and the guidance provided by the system.

(f) This section does not alter or abrogate any responsibility of the retirement system, an employer, or an agency to meet and confer in good faith with the employee organization regarding the impact of the disallowed compensation or the effect of any disallowed compensation on the rights of the employees and the obligations of the employer to its employees, including any employees who, due to the passage of time and promotion, may have become exempt from inclusion in a bargaining unit, but whose benefit was the product of collective bargaining.

(g) This section does not affect or otherwise alter a party's right to appeal any determination regarding disallowed compensation made by the system.

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section ~~31639.96~~ *31541.2* to the Government Code, imposes 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:

In order to appropriately maintain the current confidentiality of personal contact information held by ~~the~~ *a county* retirement system ~~of Orange County~~ regarding retired members of the system, and their survivors and beneficiaries, it is necessary to limit access to

this information if it is provided to other public entities for purposes of Section ~~31639.96~~ *31541.2* of the Government Code.

O

May 19, 2022

The Honorable Phillip Chen
California State Assembly
1021 O Street, Suite 4620
Sacramento, CA 95814

RE: AB 2493 (Chen): County employees' retirement: disallowed compensation: benefit adjustments.
As Amended 4/05/22 – OPPOSE
Location – Senate Labor, Public Employment and Retirement Committee

Dear Assembly Member Chen:

On behalf of the California State Association of Counties, I regret to inform you of our opposition to Assembly Bill 2493, which would place a significant financial burden on counties by requiring member agencies of county retirement systems to pay substantial penalties for decisions they did not make and over which they had no authority.

Following the passage of the Public Employees' Pension Reform Act of 2013 (PEPRA), county retirement systems took varying approaches to comply with the provisions of PEPRA related to which types of compensation may be included in retirement benefit calculations. On July 30, 2020, the California Supreme Court issued a decision in the case *Alameda County Deputy Sheriff's Assn. v Alameda County Employees' Retirement Assn.,* otherwise known as the "*Alameda* decision," in which the Court upheld provisions PEPRA related to disallowed forms of compensation for retirement calculations. Over the last two years, the impacted '37 Act systems have been working to comply with *Alameda* and recalculate retirement benefits for members who retired after January 1, 2013.

AB 2493 unfairly places the financial consequences of the Court's decision on counties by requiring '37 Act system employers to pay a "penalty" equal to 20 percent of the current actuarial value of retiree benefits deemed unlawful. The penalty, which will result in affected counties owing tens of millions of unbudgeted dollars to retirees for what the Court found to be an illegal benefit, implies counties made the decision to misapply the law. In reality, counties simply complied with the pension agreements established between employees, employers, and retirement systems.

For the reasons stated above, we must oppose AB 2493. The fiscal impact on affected counties will place a significant strain on general fund dollars, resulting in reductions to critical programs including public safety, transportation, and behavioral health. Please do not hesitate to contact me at gneill@counties.org with any questions about our position.

Respectfully,

Geoff Neill
Legislative Representative

Cc: Honorable Dave Cortese, Chair, Senate Labor, Public Employment and Retirement Committee
Honorable Members and Consultant, Senate Labor, Public Employment and Retirement Committee
Scott Seekatz, Senate Republican Caucus Consultant

June 22, 2022

TO: Each Trustee
Board of Retirement

FROM: Ricki Contreras, Division Manager
Disability Retirement Services

SUBJECT: **APPEALS FOR THE BOARD OF RETIREMENT'S MEETING OF JULY 6, 2022**

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

5248B	Michael G. Metal	In Pro Per	Deny SCD
5254B	An L. Ning	Shanon Trygstad	Deny SCD – Grant NSCD With Option of Earlier Effective Date

RC:kw
Memo.New Appeals.docx

June 14, 2022

TO: Each Trustee
Board of Retirement

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: July 6, 2022, 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.

STANLEY J. MAJCHER, M.D. – Internal Medicine/Gastroenterology
SAMUEL A. BERKMAN, M.D. – Internal Medicine/Oncology
STEVEN N. BROURMAN, M.D. – Orthopedic/Hand Surgery
JONATHAN C. GREEN, M.D. – Internal Medicine/Occupational Medicine
ROBERT B. WEBER, M.D. – Internal Medicine/Cardiovascular Medicine
PAUL J. GRODAN, M.D. - Internal Medicine/Cardiology

Attachments

RC:mb

June 21, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

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

FOR: July 6, 2022, Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
STANLEY J. MAJCHER – INTERNAL MEDICINE

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 Stanley J. Majcher, M.D. be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

The Disability Retirement Services Division engaged Garland & Associates Medical Legal Public Relations & Marketing to discuss potential candidates for the LACERA Panel of Examining Physicians. Garland & Associates purpose is to develop referrals for treatment cases, medical legal evaluations, including, impairment for Workers' Compensation, fitness for duty evaluations, and independent medical examinations, and expert witness testimony. Their network includes expertly trained and highly skilled physicians within a variety of specialties.

Stanley J. Majcher, M.D., is Board Certified in Internal Medicine with a subspecialty in Gastroenterology. He received his medical degree from Georgetown University School of Medicine in 1959 and completed residencies and fellowships in internal medicine and gastroenterology at the Veterans Administration Hospital in Washington D.C. and Long Beach, California. Dr. Majcher has over 50 years' experience performing medical legal evaluations for both public and private organizations and was a long-standing physician on the LACERA panel some years ago. He currently serves as an Associate Clinical Professor of Medicine at the University of Southern California School of Medicine.

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. Staff will also provide an overview of the Quality Control Questionnaire process and procedures.

On June 8, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Stanley J. Majcher, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Stanley J. Majcher, 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 12/27/2021
Physician Name: STANLEY J. MAJCHER	Group Name: STANLEY J. MAJCHER INC.
Primary Address: 1028 E. Walnut Creek Parkway, Suite C, West Covina, CA 91754	
Primary Contact: Marley Majcher	Title: CEO
Telephone: 626-919-5888 Fax: 626-919-5641	Email:
Secondary Address: 1806 Flower Street, Glendale CA 91201	
Telephone: 818-937-5944 Fax: 818-937-9560	Email: Scheduling@drmajcher.com

PHYSICIAN BACKGROUND	
Field of Specialty: Internal Medicine Board Certification ☒Yes ☐No	Subspecialty: Gastrointestinal Board Certification ☐Yes ☐ No
License # **G8082** Expiration Date: **6/30/2023**	
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	50	Treatment	20
IME	10	Evaluations	80
QME	25	Research	0
Workers' Compensation Evaluations	50	Teaching	0
Disability Evaluations	50		100 %

Med-Legal Reports			

Performing Medical Evaluations for Public Organizations ☒Yes ☐No

Performing Medical Evaluations for Private Organizations ☒Yes ☐No

Please Names of Organizations:

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).
No Charge

Cancelled Exams that do not adhere to your stated policy: Fee: $ **No Charge**

Cancelled Hearings that do not adhere to your stated policy: Fee: $ Click or tap here to enter text.

Name of person completing this form:

Print Name: STANLEY J. MASCHER, M.D. FACP	Title: MD FACP
Physician Signature:	Date 12/27/2022

You may attach additional pages if necessary.

Revised: 12/8/21

[redacted]

STANLEY J. MAJCHER, M.D., F.A.C.P.

1028 East Walnut Creek Parkway, Suite C
West Covina, California 91790 *send all correspondence to this address*

1781 West Romneya Drive, Suite C
Anaheim, California 92801

(626) 919-5888 *phone*
(626) 919-5641 *fax*

CURRICULUM VITAE

LICENSE: GO8082
TID: 95-4607773

PERSONAL INFORMATION

Date of Birth: [redacted]
Birthplace: [redacted]
Marital Status: [redacted]

PREMEDICAL EDUCATION

Rutgers University, B.S., 1955, New Brunswick, New Jersey

MEDICAL EDUCATION

Georgetown University School of Medicine, 1959, Washington D.C.

INTERNSHIP

Emory University Hospital, 1959-1960 (Internal Medicine), Atlanta, Georgia

RESIDENCIES AND FELLOWSHIPS

Veterans Administration Hospital, 1960-62 (Internal Medicine)
Veterans Administration Hospital, 1962-63
Washington, D.C. – Fellowship in Gastroenterology
Veterans Administration Hospital, 1963-64
Long Beach, CA – Fellowship in Gastroenterology

MEDICAL SCHOOL FACULTY APPOINTMENT

Instructor of Medicine, 1964-66
University of Southern California School of Medicine, Los Angeles, CA
Associate Clinical Professor of Medicine (Current)
University of Southern California School of Medicine, Los Angeles, CA

FELLOWSHIP

American College of Physicians

CERTIFICATION

American Board of Internal Medicine

MILITARY SERVICE

U.S. Army Medical Corps, 1968-70
Honorable Discharge as Lt. Colonel

PRIVATE PRACTICE/MEDICAL-LEGAL EXPERIENCE

I. Internal Medicine

II. Medical –Legal Experience:

A. All areas of medical/legal problems.
B. Workers Compensation.
C. Personal injury.
D. Depositions.
E. Court testimony, including expert witness.
F. Expert witness in medical malpractice.
G. Agreed Medical Examiner.
H. Independent Medical Examiner.
I. Qualified Medical Evaluator.
J. Oncology.

Stanley J. Majcher, M.D., F.A.C.P.

Board Certified in Internal Medicine
1028 East Walnut Creek Parkway, Suite C
West Covina, CA 91790-3072
626-919-5888 telephone; 626-919-5641 fax
Please send all correspondence to the above address

[redacted]

SAMPLE REPORT #1

[redacted]

Patient: [redacted]
Date of Birth:
Claim No.:
EAMS Case No.:
Date of Injury:
Employer:
Date of Evaluation:

QUALIFIED MEDICAL EXAMINATION IN INTERNAL MEDICINE
INITIAL REPORT

Dear Gentlepersons:

As requested, the patient was evaluated at my office.

This **INITIAL QUALIFIED** medical examination report is being billed as an:

ML-201

SOURCE OF FACTS

I have received correspondence from the Law Offices of [redacted] however, there are no specific details regarding internal medical issues.

I do not have any other correspondence.

Accordingly, I have to rely on the patient. The issue is uncontrolled high blood pressure.

Patient, results of medical evaluation, and any records submitted. I received an attestation and declaration to review 265 pages of records.

JOB DESCRIPTION/MECHANISM OF INJURY AS RELATED BY THE PATIENT

The patient is a [redacted]-year-old female who is an excellent historian.

She could not recall the exact date of hire at [redacted] and the best estimate is [redacted].

She had been employed as an [redacted] and worked 50 to 70 hours per week over a period of five days per week. She denies simultaneous employment. Unfortunately, she sustained major orthopedic injuries when she tripped on a wire at the workplace at some point in [redacted]. She sustained a fracture of the left ankle, injuries to both knees, back injury, and neck injury. She had tripped on some duct tape on the floor. She had multiple surgical interventions and neck surgery is scheduled for [redacted].

She resumed work activities at some point in [redacted] at an estate of a private residence whereby she "organizes everything". She lives at the residence.

There is no claim against her current employer.

Internal Medical Issues:
Hypertension. She could not recall the exact date when her pain management specialist, Dr. [redacted] advised her that she was suffering from severe high blood pressure. The diagnosis was established obviously after her major injuries. She had been under a great deal of stress obviously associated with her painful injuries. Stress commonly causes high blood pressure.

Apparently, referral to internal medical specialist/cardiology on an industrial basis was not authorized. This is surprising.

Accordingly, she has been managed by Dr. [redacted] who is a family practice physician.

She has constant dizziness associated with severe generalized headache, but no paralysis. She has substernal chest pain without radiation to neck, shoulders, or extremity associated with shortness of breath at rest.

She has noticed swelling of both ankles and pain in both calves. She is not aware of any issue of deep vein thrombosis. She denies pleuritic chest pain, fever, or chills.

PRIOR WORKERS' COMPENSATION CLAIMS

Denied.

AUTOMOBILE ACCIDENTS

Positive, but no injuries.

PAST HISTORY

She denies diabetes, tuberculosis, or hepatitis.

ALLERGIES

None.

CURRENT MEDICATIONS

Norco twice daily, Ultram twice daily, gabapentin at bedtime, and losartan 100 mg daily.

HABITS

Alcohol:	None since [redacted]. There is no history of excessive intake of alcohol.
Tobacco:	Never.

FAMILY HISTORY

Diabetes mellitus:	Negative.
Hypertension:	She is uncertain, but possibly brother, but this is not clear.
Heart disease:	Negative.

Negative for hereditary diseases.

SURGERIES

Hysterectomy and surgical interventions regarding industrial orthopedic injuries.

REVIEW OF SYSTEMS

Review of systems is essentially negative and noncontributory from the perspective of internal medicine.

General:	Denies fever, chills, significant weight change.
Eyes:	The patient denies significant pain, blurred vision.
Ears:	The patient denies significant ear pain, unusual drainage.
Nose:	The patient denies congestion, abnormal bleeding, or any significant irritation.
Throat:	The patient denies significant pain, difficulty swallowing, or other significant symptoms.
Cardiovascular:	Denies: hypertension, rheumatic fever, chest pain typical of heart disease, abnormal shortness of breath, orthopnea, PND, known heart disease, edema, or symptoms of peripheral vascular disease, except as indicated.
Respiratory:	Denies: abnormal cough, hemoptysis, bronchitis, pneumonia, cyanosis, or significant respiratory complaints, except as indicated.
Genitourinary:	Denies: frequency, polyuria, urgency, dysuria, infections, kidney stones, or other significant abnormalities.
Neuropsychiatric:	Denies: seizures, paralysis, numbness, tingling, or any significant neurologic symptoms.
Psychiatric:	Denies evaluation or treatment by a psychiatrist.
Musculoskeletal:	Denies: joint pain, stiffness, swelling, tenderness, skin lesions, gout, or knowledge of any arthritic or related problems.
Gastrointestinal:	The patient denies significant abdominal pain, nausea, vomiting, significant constipation or diarrhea, abnormal bleeding, jaundice, liver disease, gallbladder disease, abnormal mucus production, or other significant symptoms.

PHYSICAL EXAMINATION

General:	Height:	[redacted] feet and [redacted] inches
	Weight:	[redacted] pounds
	Blood pressure:	Markedly elevated at 162/102 supine and upright, and remains markedly elevated one hour later at same levels.
	Pulse:	61 to 63 and regular.

	Pulse oximetry: Normal in room air at 94%. Respirations: 18 per minute. The patient is alert, active, overweight female, and no apparent acute distress.
Head:	No evidence of trauma.
Neck:	Thyroid not enlarged; no bruits.
Skin:	No significant rashes, eruptions, ulcerations, erythema, "spiders," or telangiectasia.
Lymph nodes:	No clinically significant abnormalities.
Eyes:	Vision grossly intact; pupils normal; no icterus; fundi negative; extraocular movements normal.
Nose:	Negative.
Oral cavity:	Negative.
Lungs:	No abnormal sounds; clear to percussion.
Heart:	Size normal. No murmurs; sounds are normal; no friction rubs.
Pulses:	The following are normal: carotid, radial, bronchial, femoral, popliteal, posterior tibial, and dorsalis pedis.
Extremities:	No abnormal swelling, tenderness, tophi, ulcers, edema, clubbing or cyanosis.
Abdomen:	No abnormal tenderness, no masses palpable, no organ enlargement, bowel sounds normal, no evidence of hernia.
Neurological:	Deep tendon reflexes are normal; no pathological reflexes; sensation normal; examination is essentially negative.

STANDARD/SPECIAL INTERNAL MEDICAL DIAGNOSTIC STUDIES

1. EKG – Normal.

2. Rhythm strip – Normal. No arrhythmia.

3. Pulse oximetry – Normal on room air at 97%.

4. Echocardiogram – Diastolic dysfunction; left ventricular hypertrophy with criteria interventricular septum measuring 1.3 cm with normal 0.9 cm; left ventricular posterior wall measuring 1.1 cm with normal 0.9 cm; non-industrial atherosclerosis of mitral and aortic valves.

5. Thyroid ultrasound screen – Abnormal. There are bilateral congenital cysts; however, there is also a mass in the left lobe of the thyroid measuring 1.2 x 1.4 cm. This nonindustrial issue should be addressed by an endocrinologist on a nonindustrial basis.

6. Carotid artery ultrasound screen – Nonindustrial atherosclerosis.

7. Abdominal aorta ultrasound screen – Nonindustrial atherosclerosis.

8. Peripheral artery Doppler of lower extremity – Nonindustrial atherosclerosis.

9. Peripheral venous Doppler of lower extremity – Normal.

REVIEW OF RECORDS: (265 pages of records, Chart #1).

1. [redacted] Application for adjudication of claim for date of injury of [redacted]

   Injuries to left ankle, left knee, right knee, right hip, low back.

   The applicant is walking and tripped on a cord. There is an undated employee's claim for Workers' Compensation benefits for date of injury [redacted] Same injuries.

2 [redacted] MRI scans of the left ankle and right hip.

3. [redacted] Appears to be orthopedic evaluation from Dr. [redacted] The applicant had been reevaluated [redacted] Is AME. Had been last seen [redacted] She remains off work. She is not participated in vocational rehabilitation. She has undergone right knee surgery and currently participated in physical therapy. She has been treating with Dr. [redacted]. This is all in a different format [redacted] Medical Group. On exam, no weight or medications listed. Very thorough orthopedic evaluation and x-ray reviewed.

   Diagnoses:
   1. Strain/sprain of the cervical spine, superimposed over significant degenerative changes.
   2. Strain/Sprain of the lumbar spine, superimposed over minimal degenerative changes.

3. Status post right knee arthroscopy.
4. Status post left anterior cruciate ligament repair, old.
5. Possible re-tear or previous graft, probable degenerative tearing of the medial and lateral meniscus, left knee per MRI scan.
6. Healed fracture of the lateral malleolus, left ankle per MRI scan.

In discussion, the applicant returns for reevaluation, noted she has undergone surgery of the right knee since last being seen in April [redacted] She underwent surgery on August [redacted] with Dr. [redacted] and is currently on postop physical therapy.

She indicates the left knee surgery is being recommended for cruciate ligament repair at this time.

Based on Dr. [redacted] evaluation of the applicant currently, he finds that unlikely she would obtain benefit from arthroscopic debridement of the left knee. Although it would be a legitimate measure of treatment to carry out for the applicant's left knee condition, it certainly would be questionable as to whether it would effective or not.

The applicant's neck complaints remain essentially unchanged; however, she notes some ongoing low back pain.

However, the main problem is her knees at this time. Dr. [redacted] did attempt to send her out for repeat MRI scan of the low back, however, this has not been set up. The radiology office has a sent a letter to try to set this up. Upon receipt, there will be a supplemental report.

Additionally, the applicant's right heel is bothering her at this time as well, as she does have plantar fasciitis. It is likely consequence of injury; however, it is not uncommon to see this complaint with low back injuries.

If the applicant does not have left knee surgery, Dr. [redacted] would consider her permanent and stationary. The applicant remains a qualified injured worker. Again there were prophylactic work restrictions for the cervical spine and bilateral knees.

4. [redacted] Updated MRI of the left knee.

5. [redacted] MRI of the lumbar spine was performed. In record review are various psychological testing results from H. Gordon Blount, PhD. Additional seven-page record reviewed date of injury January 2002.

In this exam, the applicant is listed as [redacted] pounds. Multiple x-rays were reviewed from the cervical spine, lumbar spine, AP pelvis. Right hip, bilateral knees, and left ankle.

Diagnoses 1 through 10 are listed.

The applicant remains TTD.

In summary, Dr. [redacted] concurs with recommendation of weight reduction surgery so that she can lose weight and then proceed with recommended treatment for her back in the form of injections and/or facet rhizotomy. This hopefully will improve her knee condition which is nearing one year postop but it not quite there yet.

6. [redacted] AME reevaluation from Dr. [redacted].

The applicant was last evaluated [redacted] She continued treatment with Dr. [redacted] who recommended cortisone injections for her foot which were never approved.

The applicant began treating with Dr. [redacted] sometime in [redacted] He sent her for an MRI scan of the left knee on [redacted] She was told she had a broken screw in the knee.

Dr. [redacted] had recommended aquatic therapy in late [redacted] or early [redacted] to strengthen the knee before surgery.

In December [redacted], she was seen by Dr. [redacted] for surgical consultation. He recommended hamstrings and quadriceps strengthening program and ACL brace but did not recommend removing the screw.

In January or February [redacted] she began seeing Dr. [redacted] again. He had recommended total knee replacement which was performed July [redacted] with postop physical therapy including aquatic therapy for four months with improvement.

Dr. [redacted] current recommendation is for gastric bypass surgery for weight loss before proceeding with further treatment. She continues to see Dr. [redacted] and pain management on a number of occasions over the years.

He has recommended injections and facet rhizotomy; however, because of difficulty in getting good enough x-ray control to get the needles in place, he has also recommended bariatric surgery for weight loss.

Dr. [redacted] was able to do a short-term nerve block on the right side and she was pain-free on the right side for two days.

Amazing relief and she indicates that with the nerve rhizotomy or blocks, she could see her going back to work.

Again Dr. [redacted] feels gastric bypass is needed to be done and some weight lost prior to any additional injections. Her recent MRI scan was obtained [redacted].

Under current medications listed are Zanaflex, Robaxin, soma, and Elavil.

Work status, the patient indicates she is off work until December [redacted] and she began working for HealthNet 30 hours a week. She stopped working in June [redacted].

The applicant indicates she was one of 100 employees that were laid off. She denied any increased symptoms as a result of the job other than the screw loosening her knee. Apparently there is quite bit of standing involved. In record review of the [redacted], MRIs of the bilateral knees.

7. [redacted] Orthopedic reevaluation from Dr. [redacted]

Since last seen [redacted], the applicant denies any new or re-injuries. She had continued right knee pain progressively worsening.

The applicant continues to treat with Dr. [redacted] as well as pain management through Dr. [redacted] She received pain medication as well as Toradol pain injections and undergone rhizotomy.

States that Ms. [redacted] has also been seen by Dr. [redacted] who performed the left band surgery. Since the surgery, she states she lost approximately 70 pounds; however, she states she recently been gaining weight and her band needs adjustment. No other details. She was last seen [redacted] by Dr. [redacted] who performed right knee x-rays. He also recommended an inversion table; however, authorization is pending AME approval. She was last seen by Dr. [redacted] [redacted] at which time, she was given Toradol injection for low back pain.

Currently she is receiving Toradol injection as needed for back pain. She is taking Robaxin 750 mg three daily, Lodine 400 mg three daily, Zanaflex 4 mg four to six times a day, tramadol 50 mg two daily and Xanax 0.5 mg two daily. No blood pressure medications are listed. The applicant has

remained off work since last seen. There is a two-page record review reports from Dr. [redacted] and Dr. [redacted]

On exam, there is no weight noted.

Diagnoses 1 through 11 are listed.

The applicant remains TTD.

In discussion, the applicant previously underwent arthroscopy of the right knee as she is experiencing increased symptomatology. In light of this which has continued to progress with worsening, she will be referred for MRI of the right knee. The applicant continues to have problems with the right knee. She does have increased symptoms of the neck. She is to undergo an MRI scan of the cervical spine.

Additionally, she has radiographic findings of heel spurs bilaterally. As we know, after injury of January [redacted], she sustained a left ankle fracture. At this time, the heel spurs are more likely due to significant weight gain since the initial injury January [redacted].

In his history, when she entered his office, she weighed appropriately [redacted] pounds and at the time of Dr. [redacted] last examination of May [redacted] she had gotten up to [redacted] pounds.

Although Dr. [redacted] is not a bariatric specialist, based on the applicant's orthopedic conditions which would limit her ability to perform even the simplest activities of daily living, it is medically most probable that the significant weight gain is secondary to industrial injury sustained in [redacted] and thus the heel spurs that are due to significant weight will be industrially related.

Initially following the lap band procedure, she did go down to approximately [redacted] pounds, however, since the lap band, has loosened she has gone back to [redacted] pounds.

It will be appropriate for the applicant to be seen by bariatric specialist in order to tighten the lap band and allow her to continue to lose weight.

Once the applicant lose some more weight, she will be able to proceed with the injections as well as rhizotomy being recommended by Dr. [redacted] We will await updated MRI scans for review.

Dr. [redacted] opinion regarding causation remained essentially unchanged due to the trip and fall injury [redacted] causing injury to the neck, back,

bilateral knees, and bilateral lower extremities. There are other pre-existing factors that do contribute to the applicant's overall disability which were previously noted in [redacted] report.

8. [redacted] PR-2 report from Dr. [redacted] This notes a refill of Micardis 80 mg. Referred to pain management.

9. [redacted] PR-2 report from Dr. [redacted], complaint of swelling.

Diagnoses: Status post trip and fall, hypertension, swelling secondary to Micardis and kidney stone.

10. [redacted] PR-2 report from Dr [redacted] The complaints list is unchanged.

Diagnoses: Hypertension, chronic neck, back, and bilateral knee pain.

Treatment plan is to discontinue Microdox and change to Atacand. She is given Z-Pak for cellulitis. She was status post right knee surgery.

11. [redacted] Entry for PR-2 report from Dr. [redacted]. Indicates the applicant is awaiting right knee surgery and had increased blood pressure. No values given.

Assessment: Status post trip and fall, hypertension uncontrolled. Also the applicant is status post left hand surgery with questionable mild pain. Rule out sleep apnea and kidney stones.

Dr. [redacted] had wanted to prescribe additional amlodipine and electrocardiogram as well as sleep study was ordered. 4.5-page record review, no blood pressure is listed and no additional internal medicine reports. Very thorough orthopedic evaluation.

X-rays of the right foot three views reveal overall osseous density and structure is normal. There was some radiodensity in the proximal phalanx of the second toe which could be from a healed fracture.

Diagnoses: At this time is:

1. Strain/sprain of the cervical spine superimposed on significant degenerative changes.
2. Strain/sprain of the lumbar spine superimposed on minimal degenerative changes, particularly at L5-S1.

3. Status post arthroscopic right knee surgery, [redacted].
4. Old left anterior cruciate ligament repair with subsequent revisions due to complications that are all old.
5. Status post anterior cruciate ligament reconstruction using allograft, Achilles tendon, posterior cruciate ligament tightening, partial medial and lateral meniscectomy, lysis of adhesions, extensive synovectomy, chondroplasty of the patellofemoral joint, bone fragment debridement removal, left knee [redacted]
6. Evidence of broken screw, left ACL repair, per [redacted] MRI scan of the left knee.
7. Status post left total knee arthroplasty, July [redacted]
8. Right heel spur, resolved.
9. Healed fracture of the lateral malleolus, left ankle.
10. Healed fracture of the second right toe with bunion, hallux valgus per x-rays of [redacted]
11. Obesity. No weight listed. The applicant remains TTD.

In discussion, on orthopedic reevaluation, she has ongoing complaints of pain in the neck, upper and lower back, bilateral knees and right foot. Since last evaluated [redacted] she continues to receive treatment with Dr. [redacted] as well as Dr. [redacted]. She is undergoing right knee arthroscopically [redacted] with some benefit.

Currently, the applicant continues to complain of ongoing symptoms of the neck which she states is improved somewhat. Her exam did reveal some tenderness from the occiput to the sacrum as well as some decreased range of motion. She has undergone appropriate treatment to include facet joint blocks. She continues to use medication for pain which is appropriate. Otherwise, Dr. [redacted] has no recommendations for active treatment at this time. She continues with ongoing pain and problems with the mid and low back.

Clinically, she has some tenderness from the occiput to the sacrum. There is some decreased range of motion. Antalgic gait on the right. There is a positive Fabre's maneuver on the right.

The applicant has undergone extensive treatment for the back includes facet blocks, rhizotomy, lap band surgery for weight reduction.

Due to her altered gait, it is probable that she would continue to experience problems with her low back. She continues to receive appropriate medications. She admitted to attending aqua therapy for a period of time which is helpful.

It is Dr. [redacted] opinion that it would be cost effective, provided with

one-year membership of the YMCA to have access to a pool.

With respect to the right knee, she continues to have ongoing complaints; however, she states surgery has been helpful. Based on recent surgeries, she is not quite yet permanent and stationary. Last page of the report is missing.

12. [redacted] She underwent right knee surgery and repair of tear. She had 12 sessions of postop therapy. She continues to treat in pain management, Dr. [redacted] She was given Toradol injections at her visits. She is to continue routine followups and medication refills, last time being [redacted] when she underwent rhizotomy at L4-L5.

She has also undergone a series of facet blocks, medial branch block for the cervical and lumbar spine which she states did not help. Physical therapy was ordered [redacted]

She was also referred to Dr. [redacted] X-rays of the right foot revealed a fracture. Authorization was requested for surgery of right foot which is still pending.

The applicant was experiencing migraine headaches with blurry vision was seen by an eye doctor. She was informed that she had an impacted cataract. No other details.

Current medications listed are Robaxin three daily, Ultram three daily, Norco three daily, Zanaflex one, Xanax one to two at bedtime, gabapentin 300 mg three daily, and verapamil 180 mg twice daily, Atacand 8 mg twice daily, and Imitrex as needed. Epworth Sleepiness Scale score was listed as 2. The applicant remains off work. There is a 13-page record review, the majority of records are orthopedic from Dr. [redacted] and Dr. [redacted] in pain management.

13. [redacted] Paperwork from WCAB assigned by the applicant and attorney Mr. [redacted]. Applicant for adjudication of claim and alleges injury to the right foot, right hallux, abductovalgus with bunion formation, second and fifth hammertoes, plantar plate tear of the second MTP joint, right foot, metatarsalgia and capsulitis, as compensatable consequences determined by [redacted]

14. [redacted] Additional orthopedic AME from Dr. [redacted]

Since last seen in the office [redacted] she continues to treat with Dr. [redacted] last being seen on [redacted].

15. [redacted] She underwent a right foot surgery with Dr. [redacted] The applicant just recently started walking again.

Dr. [redacted] was informed that she has the same issues in the left foot and she needed surgery. She is pending authorization.

16. [redacted] She states she fainted. She went to [redacted] Medical Center ER. She was instructed to go to the hospital but went home. The following day, she returned to Medical Center as her symptoms did not improve. She was admitted for observation overnight.

She was notified that she fainted due to an allergic reaction and blood pressure medication she was taking. No other details.

17. [redacted] She states she fell down on the evening after her legs buckled as she was walking into the kitchen.

She put her arms out to break the fall and landed on the right middle finger, right hip, and right knee. She was seen at urgent care in [redacted] and evaluated by Dr. [redacted] X-rays were obtained and she was diagnosed with sprain of the wrist and a fracture of the left middle finger. She had increased right knee symptoms.

The applicant's is currently taking Ultram and Norco. No other medications listed. Epworth Sleepiness Scale score today was 12. The applicant remains off work. There is a 4.5-page record review, but there are records from Dr. [redacted] and Dr. [redacted] Records from [redacted] Medical Center are not available.

On exam, listed as [redacted] feet [redacted] inches, [redacted] pounds as stated. She states she has gained nearly 20 pounds since having her right foot operated on. No assistive devices.

Diagnoses 1 through 12 are listed. The applicant remains TTD.

When last evaluated [redacted] Dr. [redacted] did not have any recommendations for treatment of the neck or left knee.

For the low back problems, he recommended she continue to receive

physical therapy and be provided with one year membership at YMCA with pool access.

For the right knee, she was postop and recommended continued postop therapy. For the right foot, he recommended surgical correction of the hammertoes and a corn on the top of the second toe.

Since last seen here, she had surgery on the right foot and also received medial branch blocks in March [redacted] by Dr. [redacted] and in April [redacted] she underwent radiofrequency neurotomy procedure.

The applicant reports significant pain relief following the radiofrequency neurotomy/rhizotomy. She wishes to proceed with another round of injections.

The applicant feels that her right foot surgery has been helpful and she would like to proceed with surgery on the left side since she is having similar problems on the left as well.

The applicant indicates she had a fall in March [redacted] and a fracture of the left middle finger.

During today's evaluation, Dr. [redacted] did not examine the left long finger as he did not want to as she is still in a splint. She did have some swelling in the DIP joint and inflammation. We will give this time to heal. No specific recommendations for treatment of left long finger at this time.

As for the applicant's low back, she is having constant pain. On exam, she has tenderness and decreased range of motion. There was also some paresthesia over the medial right leg. Given that she has had improvement with treatment by Dr. [redacted], injection in the past, additional injections would seem reasonable.

The applicant is status post right foot surgery October [redacted] She still has some tenderness with scar in the plantar surface of the second metatarsal and stiffness, although her right second toe is straight and she has gotten rid of the corn.

The applicant states following the surgery, she gained 20 pounds as she is off her feet for almost three months. She would like to proceed with surgery to the left.

Dr. [redacted] performed a fusion of the PIP joint of the second toe and on x-rays, Dr. [redacted] looks like there has been some modification of the second metatarsal head.

The surgery that was done is certainly different from what Dr. [redacted] would have done, but it certainly Dr. [redacted] choice of procedure that he does because he takes the blame or credit for the results.

The applicant uses crutches and a walker postop for the right foot. Dr. [redacted] felt she will probably do better with a pair of elbow crutches. If the elbow crutches do not work, there are still traditional crutches and a walker at home. The elbow crutches are not expensive so it is worth trying.

Currently the applicant is taking four to five Norco per day for pain as well as Ultram. She continued treatment rhizotomies for the lumbar spine and proceeding out with surgery of the left foot. Doctor would be happy to reevaluate after treatment is completed. Again, Dr. [redacted] has continued to find that the [redacted] injury contributes significantly, if not at all to her distally cervical spine and lumbar spine, bilateral knees, and left ankle.

As a compensatable consequence since [redacted] injury, she suffered an injury to bilateral feet as well as recent injury to the middle finger. Doctor previously discussed pre-existing pathology attributed to her cervical spine and right knee and left knee.

18. [redacted] Orthopedic reevaluation from Dr. [redacted] The applicant's history of injury and treatment today again reviewed.

The applicant was last seen by Dr. [redacted] pain management [redacted] She received additional physical therapy which is helpful, however, she had to stop as she is unable to obtain treatment in her area. She would like to have additional therapy as it was helpful. She has also received aquatic therapy one to two times per week with benefit.

19. [redacted] Dr. [redacted] has recommended total knee replacement on the right, which she would undergo tomorrow if it was authorized. She continues to see Dr. [redacted] in pain management. She underwent rhizotomy of the cervical and lumbar spine [redacted] with good result so far. She was given Toradol injections [redacted] and a series of trigger point injections to the cervical spine with transient benefits.

The applicant also continues to see Dr. [redacted] who recommended right knee replacement, unfortunately he passed away in December [redacted].

Under current medications are Ultram 50 mg two to three daily. Norco 10/325 mg two to three daily, gabapentin 300 mg p.m., Xanax 0.5 mg p.m.,

and losartan, no dosage. She also takes OTC Advil and sinus medications. Orthopedic complaints again reviewed in detail. Epworth Sleepiness Scale score was 2.

Since last seen here [redacted] she remains off work. Additional 5-page record review noted from reports from and Dr. [redacted] and Dr. [redacted]

On exam, weight is unchanged [redacted] pounds. Very thorough orthopedic evaluation.

X-rays complete views four views of the right knee revealed no cartilage space narrowing. Complete views four views of left knee revealed a total knee replacement and well seated. Weightbearing view one view both knees is normal.

Diagnoses:

1. Cervical spine S/S with 2 to 3 mm disc bulge with neural foraminal stenosis at C5-C6 and 2 to 3 mm disc bulge with neural foraminal stenosis at C6-C7 per the MRI scan of [redacted]
2. Bilateral wrist S/S.
3. Status post left middle finger fracture due to a fall in kitchen, [redacted] compensatable consequence, healed.
4. Lumbar spine S/S with 5 mm left L4-L5 facet joint synovial cyst protruding medially into the lumbar spine canal and resulting in moderate to severe left L4-L5 lateral recess stenosis with medial displacement and potential for impingement on the traversing left L5 nerve root per MRI scan [redacted]
5. Lumbar spine degenerative changes, greatest at L5-S1, per radiographs [redacted]
6. Status post right knee debridement of medial synovial plica, partial medial and lateral meniscectomies, abrasion chondroplasty, [redacted]
7. Status post repeat right knee surgery procedure unknown, date unknown, per the applicant.
8. Status post prior left knee anterior cruciate ligament reconstruction, [redacted].
9. Status post left knee anterior cruciate ligament reconstruction using Achilles tendon allograft, posterior cruciate ligament tightening, partial medial and lateral meniscectomy, lysis of adhesions, extensive synovectomy, chondroplasty of the patellofemoral joint, bone fragment debridement and removal, [redacted]
10. Status post left total knee replacement July [redacted], operative report not provided.
11. Fracture of the lateral malleolus, left ankle, healed per MRI scan of [redacted]

12. Heel spurs, asymptomatic.
13. Fracture second right toe with bunion, hallux valgus, status post modifies osteo bunionectomy with internal fixation, hammertoe repair, open reduction and internal fixation and plantar plate repair on the second metatarsophalangeal joint, [redacted]
14. Left second toe bunion hammertoe.

In discussion, the applicant remains TTD and need further treatment regarding right knee and left foot. Again doctor reviews his analysis and apportionment issues from his [redacted] report.

20 [redacted] Orthopedic AME from Dr. [redacted]

Since last seen [redacted] she reports several falls due to right knee buckling. She does not recall the details but believes she had approximately five falls causing minor injuries that did not require medical treatment.

21. [redacted] Deposition with Dr. [redacted] ortho AME. Pages 1 to 10.

22. [redacted] Reports from Dr. [redacted]

On exam, the applicant is listed as 5 feet 10.5 inches, 200 pounds. More thorough evaluation.

Diagnoses 1 through 14 are listed.

The applicant has not yet reached MMI. In discussion, one of the questions Dr. [redacted] have been asked, there is a reasonable necessity of the surgery she had at the L4-L5 level [redacted]

From what can be gleaned from the x-rays as well as medical reports that had been provided, she had a decompression of the right S1 nerve root and fusion at L4-L5 level which was done by Dr. [redacted] for severe stenosis at that level due to synovial cyst.

She was having weakness of the lower extremities and urgency with urination.

Dr. [redacted] has felt the surgery is reasonable to do and she feels the surgery has helped reduce her pain significantly.

The surgery was done six months ago and she still feels she is getting

stronger.

This surgery has been beneficial. As far as the low back is, she has not reached MMI.

While discussing the applicant's of problems, it seems the applicant's biggest single problem now is the right knee. X-rays taken at the time of the last evaluation revealed bone-on-bone. She is a candidate for total knee arthroplasty but this cannot be performed at this point until she has completed healing for low back. She is to follow up with Dr. Roger.

The applicant is getting paracervical injections from pain management physician. Her neck pain fluctuates and more or less as the same as it was before. This is not a major problem for her and does not need major treatment other than pain management at this point.

On exam, the applicant has multiple hammertoes in both feet. Not caused directly by her work injury, but they are probably compensatable consequence from limping around and falling. She may require surgery on a future date but at this point, she is not a candidate for surgery of her feet because of her back and right knee. She is to proceed with right knee surgery first.

23. [redacted] Orthopedic reevaluation by Dr. [redacted] The applicant was last evaluated [redacted] The patient continues treatment with Dr. [redacted] for routine followups and medication refills. She had an updated MRI of the right knee, it was requested, however, was not authorized. There is notation for referral from Dr. [redacted] to Dr. [redacted] for evaluation of a cyst on the L5 vertebrae that was removed [redacted] Surgery was helpful. She continues to treat with Dr. [redacted] and pain management. She was given multiple trigger point injections, Toradol injections, along with medication refills.

Medications listed are Norco, tramadol, ibuprofen, alprazolam, and gabapentin along with medicated ointments. Epworth Sleepiness Scale score was 3. The applicant remains off work. There is a 2.5-page record review noted including updated [redacted] MRI of the lumbar spine.

24. [redacted] Pain management note from Dr. [redacted] The applicant still receiving acupuncture. Weight remains unknown and that she has gained weight several pounds, still exercising. Has two dogs.

On exam blood pressure 171/105, pulse 61. Diagnoses I through XIV

unchanged. The applicant is given for refills of Norco, gabapentin and Xanax, Toradol injection.

25. [redacted] Pain management note from Dr. [redacted]

Workers' Compensation approved 12 sessions of acupunctured by Tina [redacted] pain. Last session was this past Monday. She was going to acupuncture two weeks or so believes it have been more helpful. She went BIW rather than twice a month. He has attempted to treat her various areas of pain with infrared therapy. Weight remains unknown.

On this exam blood pressure is 173/94, pulse 59. Diagnosis I through XIV are listed. Refills with Norco, gabapentin, and Xanax, was scheduled right TKR with Dr. Rodger.

We also given a Z PAK for "sinus infection"

26. [redacted] Pain management note from Dr. [redacted] The applicant never got her own infrared therapy unit to treat her various areas of pain but does use her friend's unit with benefit. When she is visiting her friend. Weight remains unknown but she believes she has gained. She is still exercising and fit 42. She has two dogs. Medications for blood pressure are unchanged.

On exam blood pressure is 141/77, pulse 53. Diagnoses I through XIV listed. Prescriptions given for Norco, and Xanax. Toradol injection.

27. [redacted] Pain management note from Dr. [redacted] Weight [redacted] pounds. Medications unchanged.

Sleeping is continues to improve on CPAP. Menthol CBD is helpful.

On exam, blood pressure is 144/101, pulse 64. Toradol injection given. Prescription for Norco, Xanax, and gabapentin.

28. [redacted] Pain management note from Dr. [redacted].

The applicant still exercising and fit in 42, weight [redacted] pounds. Walking with two adopted dogs.

AME recommended right TKR and left foot surgery. No surgery scheduled yet. "I am waiting."

The applicant is seen with Dr. [redacted] regarding her right total knee replacement under Medicare.

Current Medications here losartan 25 mg, HCTZ 12.5 mg and CBD role-on.

On exam, blood pressure 142/76, pulse 62. Prescription given for Norco, Xanax and gabapentin. Toradol injection.

29. [redacted] Orthopedic AME from Dr. [redacted]

The applicant was last seen here [redacted] She states she sustained multiple falls due to knees buckling which unfortunately as a result of minor scrapes and bruises, does not require any medical attention.

She continues to treat with Dr. [redacted] for routine followup with medication refills.

She attended 24 sessions of acupuncture for the neck and low back which were helpful. She last attended acupuncture May [redacted]

Dr. [redacted] has recommended right total knee replacement and all requests have been not approved at this point. She was last seen by Dr. [redacted]. The applicant continues in pain management for monthly reevaluations with Dr [redacted] She also received Toradol injections. She was last seen for refill of medications July [redacted]

The applicant indicates she has been paying out of pocket for physical therapy for neck and low back approximately twice per week.

The applicant is currently taking Norco 7.5/325 mg twice a day, tramadol 50 mg as needed, gabapentin 200 mg x2 q.h.s., Xanax 0.5 mg as needed, losartan, no dosage, celecoxib and pantoprazole. The applicant remains off work. Epworth Sleepiness Scale score was 6. One-page record review is noted. On exam, no weight noted. Exam is limited to the bilateral knees. The applicant is able to walk on heels and toes satisfactory. Full squat. Range of motion decreased.

X-rays of the right knee three views revealed almost no cartilage. Weightbearing view of the bilateral knees one view shows that she has had total knee replacement on the left. Everything appears stable and appropriate.

Diagnoses 1 through 14 are listed.

The applicant is yet to reach MMI.

In discussion, the applicant is a reasonable candidate for total knee replacement on the right. Her treating physician wanted to operate on her but it was not certified.

As long as she is concerned, the applicant remains TTD until she is provided appropriate treatment for the right knee.

30. [redacted] Pain management note from Dr. [redacted] Her current weight is listed as [redacted] pounds. On exam, blood pressure 144/84, pulse 64, status unchanged. Scripts given for Norco, x40, Xanax, Gabapentin. Toradol injection given.

31. [redacted] Followup note from Dr. Rosenbloom.

Blood pressure 144/105. Diagnosis I through IV listed, Toradol injection. Scripts given for Norco, Xanax, Gabapentin and also script for Ultram 50 mg.

32. [redacted] Pain management note from Dr. [redacted]

Just found out she has labral tear of the right hip. She has lost weight dud to GERD despite Protonix 40 mg a.m. and Zantac 300 mg q.h.s. for GERD/hiatal hernia.

Barium swallow confirmed an obstruction possibly related to a lap band which would be evaluated by Dr. [redacted]

Weight unknown, [redacted]. No time for exercise other than walking her two adopted giant Schnauzers around the complex as tolerated. Knee complains can make walking with the dog difficult.

Still waiting AME recommendations for right knee and left foot.

On exam, blood pressure 170/98, pulse 88. No actual weight. Diagnoses I through XV listed. Toradol injection. Prescriptions for Norco, Xanax, gabapentin and Ultram.

In discussion, Dr. [redacted] is pleased the applicant had barium swallow and she certainly have a lap band reevaluated to this sudden onset of

symptomatic GERD.

33. [redacted] Pain management note from Dr. [redacted]

Weight remains unknown but she is certainly "more slender." My back and right knee are hurting today. Still exercising with walking dogs. She walks with dog one to two miles b.i.d. Rental situation remains unchanged. She is still using cane or walking stick p.r.n.

Medications listed are losartan 25 mg. HCTZ is not listed.

Menthol CBD role-on is helpful from neck, back and right knee. No longer eating the THC cookies for sleep.

Blood pressure today is 137/80, pulse 60.

Diagnoses I through XIV. The applicant will continue prior refills except for Neurontin. Adds Norco and Xanax. Please note remaining records, no actual records regarding the applicant's lap band surgery or status post lithotripsy and ureteral stent insertion records.

34. [redacted] Additional amendment to application for adjudication of claim without the actual application of adjudication claim signed by the applicant.

Alleges injury now to the right hip.

35. [redacted] Pain management note from Dr. [redacted]

One of the applicant's rescue dogs died of Non-Hodgkin lymphoma. She has significant labral tear of the right hip "it is carrying me end of here." She would go to DOCfor followup and likely have THR. She did have a heparin injection with benefit. She states current quantities of Norco have been inadequate.

Apparently the applicant's GERD resolved when Dr. [redacted] emptied her lap band. No longer on Protonix 40 mg or Zantac 300 mg q.h.s. for GERD/hiatal hernia.

She has gained 10 pounds and Dr. [redacted] will likely do a lap band next week.

If this has not work well, Dr. [redacted] wants her to proceed with gastric

bypass. Her current weight is listed as [redacted] pounds. She has no further acupuncture or required therapy. She will resume exercise and care for fit in 42. The rental situation remains unchanged.

"My back is fine." There is no new news regarding AME's recommendation for right TKR or left foot surgery. She continues to followup with Dr. Roger, if surgery with TKR is necessary. Her other medications include losartan 25 mg, gabapentin 300 mg two daily, Ultram b.i.d., Norco 10/325 mg two to three tablets daily. Xanax. She is using CPAP nightly and also a menthol CBD role-on for her elbow for neck and back. She states she claims to be compliant with antihypertensive. Good days and bad days regarding all components including her right knee that can buckle. She has better pain relief with the combination of Ultram and Norco.

On exam today blood pressure is 148/88, pulse 62. Diagnosis I through XV were listed. Continue exercise. The applicant is given Toradol injection today. Prescription given for Norco x60, Xanax, gabapentin and Ultram. She is still awaiting AME report.

36. [redacted] Pain management note from Dr. [redacted]

The applicant is having issues with sores of her oral mucosa and blisters over the lips ? etiology. Unresponsive to various antifungals, antibiotics, and other medications.

Possible weight loss related to this. She continues to treat for right hip and right knee. Dr. [redacted] emptied her lap band but has not filled it yet. "I haven't followed through." Current weight is listed as [redacted] pounds. No news regarding AME's recommendations for right TKR, and left bunionectomy. The applicant was told that she had stage III renal insufficiency and would be referred to nephrologist and nutritionist.

On exam today, blood pressure is 179/98, pulse 60, weight [redacted] pounds. Urine drug screen unchanged.

Diagnoses 1 through 15 are listed.

Scripts given for Norco, Ultram, and gabapentin. Follow up with various specialists.

37. [redacted] Volume II deposition with Dr. [redacted] ortho AME. Pages 1 to 24. Of note, there is an undated pain management note from Dr. [redacted]

office with status post right TKR of [redacted] Low back complaints are reviewed. No upper extremity symptoms. Intermittent neck pain.

On this exam, blood pressure is 159/93, pulse 64, weight [redacted] pounds.

Impression and Plan:

1. Active labral tear, right hip.
2. Active status post right TKR [redacted]
3. Active [redacted] status post bilateral L4-L5 hemilaminectomy, medial facetectomy, and foraminotomies with excision of epidural mass and fusion with bone graft.
4. Active, left lumbar radiculitis.
5. Active lumbar facet joint pain.
6. Active left-sided low back pain secondary to an L4-L5 facet JT cyst with potential for nerve impingement.
7. Status post right podiatric surgery [redacted]
8. Active, left bunion and left second hammertoe.
9. Cervical facet syndrome with cervicogenic headaches.
10. Cervical DDD and facet arthropathy.
11. Occipital neuralgias.
12. Status post right knee arthroscopy [redacted]
13. HTN exacerbated by chronic pain, not under adequate control by PCP.
14. Associated mood and sleep disorder.
15. Obesity, status post left band.
16. Calculus, left renal pelvis, status post lithotripsy and ureteral stent insertion.

Current medications here are gabapentin, Norco, and Xanax. The applicant is given Toradol injection. The applicant is to consult with orthopedist, Dr. [redacted] regarding labral tear of the right hip. She is to follow up with Dr. [redacted] as scheduled regarding TKR. Refill of gabapentin. The applicant will obtain controlled substances from another prescriber but no details given. Continue physical therapy.

38. [redacted] Followup note from Dr. [redacted]. Current weight [redacted] pounds. No recent exercise due to pain complaints.

Apparently renal situation remains unchanged. No news regarding AME recommendations for right total knee replacement with left bunionectomy. She continues to see Dr. [redacted] who will be the surgeon to perform the TKR if necessary.

She is using CPAP nightly. Currently Dr. [redacted] and Dr. [redacted] are

concerned about BP. Crit is at 1.29 with upper normal limits of normal at 1.0.

On exam, blood pressure is 171/101, pulse 63, weight [redacted] pounds.

Toradol injection given. Scripts of Norco, Ultram, Xanax, and gabapentin.

The applicant is to follow up with PCP regarding HTN. The applicant can certainly increase her daily dose of losartan which is listed as 25 mg.

39. [redacted] Pain management note from Dr. [redacted]

The applicant has been experiencing tolerable right hip pain. Right knee can buckle and cause her to collapse. She is to follow up with Dr. [redacted] to see whether her lumbar spine could be responsible for any of the symptoms.

Dr. [redacted] at DLC ordered MRI which revealed significant labral tear of the right hip. She did have a hip injection with benefit.

However, Dr. [redacted] also feels that the hip pain is emanating from the lumbar spine. Current weight is [redacted] pounds. Dr. [redacted] emptied her lap band but has not filled it yet. Has been prescribed medications for possible fungal infection of the mouth by different physicians, we will get them refilled today. No news regarding AME recommendations for right knee and left foot surgery.

The applicant is using CPAP but is not taking any antihypertensive for four to five days.

On exam today, blood pressure is 178/102, pulse 57.

The applicant was given Toradol injection. Scripts for Norco, Xanax, gabapentin, we will change Ultram 50 mg to Ultram ER 100 mg. Follow up with various specialists.

40. [redacted] Pain management note from Dr. [redacted]

Blood pressure is 148/79, pulse 66, weight [redacted] pounds.

Diagnoses 1 through 15 are listed.

Refill given on Norco, Xanax, Ultram, and gabapentin.

Apparently, insurance will not pay for Ultram ER and coincidentally this is when her pain started waking her overnight. In an attempt to improve her sleep, we will try Remeron 15 mg. We will follow up on her crit at next visit.

41. [redacted] Pain management note from Dr. [redacted]. The applicant is scheduled for right TKR by Dr. [redacted] Apparently she is seeing her PCP who will refer to dermatology and ENT specialists. She did see Dr. [redacted] who referred her to physical therapy for right hip dysfunction and continues to see Dr. [redacted] who does not feel there is anything he can do for her.

The labial lesions vary in severity just as do her oral lesions. Right knee buckling. Her current weight is [redacted] pounds. She is following up Dr. [redacted] She is using CPAP nightly.

On exam today, blood pressure is 165/88, pulse 58, weight [redacted] pounds.

Undated urine drug screen. Positive for THC, BZO, OPI.

Diagnoses: 1 through 15 are listed. The applicant was given Toradol injection. She is given a script for Norco 10/325 mg x60, Xanax, Ultram, and gabapentin.

The applicant states she gets a couple of days of relief from each IM injection.

42. [redacted] Pain management note from Dr. [redacted]

Blood pressure is 161/110, pulse 63.

Diagnoses 1 through 16 are listed.

Current medications are gabapentin, Norco, and Xanax. The applicant was given Toradol injection. She is to start physical therapy, as prescribed by orthopedist.

43. [redacted] Chart note from Dr. [redacted] The applicant is status post right knee replacement with Dr. [redacted] Uneventful recovery. Home physical therapy two times a week and additional physical therapy at [redacted] PT twice a week.

The applicant was using prednisone cream on lips with benefit, severity of

the lip swelling and oral mucosal lesions varies from day to day. She is yet to see ENT physician regarding this now chronic problem.

Labial lesions remain resolved. She will see gynecologist tomorrow.

Dr. [redacted] emptied her lap band but it was not filled yet.

Apparently, Dr. [redacted] wants to do more extensive gastric bypass surgery. The applicant has tried to maintain weight on her own.

AME appointment was rescheduled on 1[redacted] due to knee surgery. Other medications include losartan at 25 mg q.d., gabapentin 300 and 600 mg, a.m. and q.h.s. Ultram b.i.d., Norco 10/325 mg two daily, Xanax 0.5 mg b.i.d.

The applicant's labral tear of the right hip has been very problematic complaint averaging 8/10 pain. The rest of that report is missing.

44. [redacted] Pain management note from Dr [redacted]

The applicant is now on Protonix 40 mg a.m., Xantax 3 mg, q.h.s.,with GERD/hiatal hernia.

She is leaving for Belize tomorrow for two weeks. No recent exercise and fit in 42 BIW-TIW due to acid reflux. She adopted two giant Schnauzers.

On exam, blood pressure 166/92, pulse 57, no weight noted. Diagnoses I through XIV. Scripts given for Norco, Xanax and Gabapentin. Waiting AME report.

45. [redacted] Pain management note by Dr. [redacted] The applicant is status post podiatric surgery, right first and second toes.

On exam today, blood pressure is 135/79, pulse 74, weight [redacted] pounds.

Diagnoses 1 through 16 are listed.

There are no records regarding lap band surgery or ureteral stent insertion. The applicant was given refill of gabapentin. Also noted, she will continue with physical therapy. She has various specialists to follow up. Doctor is pleased that the right IA hip injection was of benefit. Apparently other medications are from different physicians.

46. [redacted] Orthopedic AME from Dr. [redacted] Reevaluation.

The applicant's injury had occurred in [redacted] under the overriding schedule. Additional 175 of records have been reviewed.

Since the applicant's prior evaluation [redacted], she states she was referred for additional physical therapy for right knee. She is currently doing home exercise program.

She also indicates she has not been evaluated by her podiatrist for the right second toe as the podiatrist has passed away. She is having a hard time finding someone who will take her case.

She states however she finally found a podiatrist willing to take care of her, however, she states insurance carrier denied treatment with this physician. She has also been experiencing pain to the second left toe for some time now which she attributes to overcompensation as she has been walking with a limp for years. The applicant continues to follow up with [redacted] for the right knee and has a followup scheduled in July [redacted].

Current medications include gabapentin, tramadol, and Norco. Of note, Epworth Sleepiness Scale score was 2.

Since her prior evaluation [redacted], she has remained TTD until April or May [redacted]

She began working as an estate manager. She states that her new employment aggravated her cervical spine, lumbar spine, and feet. However, she has the opportunity to rest as needed. There are listed 175 pages of records available for review with majority being from Dr. [redacted]. There is also reference to a surveillance video from [redacted] to [redacted] Dr. [redacted] is the person in the video as appropriate patient as he has no independent recollection of her.

On exam, the applicant is listed as 5 feet 10 inches, [redacted] plus pounds stated. No assistive devices. Very thorough orthopedic evaluation. Undated x-rays of the right knee four views reveal a stable and well-positioned knee replacement. Weightbearing x-rays one view of both knees reveal well-seated bilateral knee arthroplasties.

Diagnoses:

1. Sprain/strain of the cervical spine with degenerative changes, particularly at C5-C6 and C6-C7.
2. Bilateral wrist strain, resolved.

3. Status post fracture of left middle finger, healed.
4. Status post L4-L5 fusion with instrumentation, by history.
5. Right hip labral tear, per history.
6. Status post right knee debridement of medial synovial plica, partial medial and lateral meniscectomies and abrasion chondroplasty.
7. Status post right knee total arthroplasty, by history[redacted]
8. Status post left knee anterior cruciate ligament reconstruction, partial medial and lateral meniscectomies, lysis of adhesions, extensive synovectomy, chondroplasty of patellofemoral joint, bone fragment debridement and removal[redacted]
9. Status post total knee arthroplasty July[redacted]
10. Fracture, left lateral medial malleolus, healed.
11. Heel spurs, asymptomatic.
12. Fracture, right second toe with bunion, status post modified osteo bunionectomy with internal fixation, hammertoe repair, open reduction and internal fixation and plantar plate repair, metatarsophalangeal joint[redacted]
13. Multiple hammertoes, on the right.
14. Left second toe bunion and multiple hammertoes.

The applicant has reached MMI.

In discussion, she returns for orthopedic reevaluation. The applicant sufficiently recovered from the right total knee replacement in July[redacted] Her right knee is doing quite well. She started working as an estate manager without too much difficulty.

The only ongoing medical treatment she is pursuing at this time is a podiatric treatment for the right second toe. She finally found and located a podiatrist who will treat her; however, all requests for treatment had been denied.

The applicant is having problems with the neck. Clinically, there is not too much to find on exam. There is minimally reduced range of motion. Provocative testing normal. Sensory motor exam unremarkable.

With respect to the lumbar spine, exam reveals some limited range of motion with tenderness over the thoracolumbar junction. She has returned to baseline since suffering a bad fall in the bathroom.

The right hip exam was entirely normal, full range of motion without tenderness.

The applicant has really gotten good results from her right total knee replacement. With the left, she continues to do well. Dr.[redacted] will defer

any treatment recommendations to podiatrist regarding her bilateral feet.

At this point, she is at a stable point of recovery and is unlikely that further conservative treatment is going to be beneficial. Although she will need access to treat and medical care, she is essentially MMI.

The applicant is given prophylactic work restrictions for the cervical spine to avoid heavy lifting, repetitive flexion, extension. For lumbar spine, she is to avoid heavy work activities.

For the bilateral knees, she is to avoid prolonged weightbearing and walking on uneven surfaces, kneeling, squatting, or climbing. For the second right toe, she is to avoid prolonged weightbearing.

Doctor continues to apportion 25% cervical disability due to pre-existing pathology, 75% due to [redacted] injury. Lumbar spine is 100% apportioned to [redacted] injury.

The right knee, 80% due to consequences of [redacted] injury. 20% pre-existing. Her left knee had previous injury and surgery is 50% apportioned to that and 50% to the [redacted] industrial injury.

For the right second toe, she has the same congenital issues with the left second toe, is apportioned 50% pre-existing pathology, 50% due to consequences of [redacted] date of injury.

The applicant's cervical spine is category 2 for 5% whole person impairment. Lumbar spine is 10% whole person impairment. Right hip 0% whole person impairment. Again the applicant has a subtotal 70 points regarding each knee. It converts to a 20% whole person impairment. Right second toe, there is 1% whole person impairment.

47. [redacted] Supplemental orthopedic AME report from Dr. [redacted]

The applicant is last seen [redacted] Dr. [redacted] is in receipt of his deposition testimony and cover letter requesting more detailed report describing future medical care.

In discussion, at the time of Dr. [redacted] recent deposition taken [redacted] it had been requested he provide more detailed recommendations in terms of future medical care.

Future medical care should include conservative measures for specific flare-ups, orthopedic reevaluation, and appropriate conservative measures if

indicated. These recommendations apply to all of her areas of complaint, cervical and lumbar spine, wrist, right hip, both knees, left ankle and feet.

This could include a course of physical therapy up to 24 sessions depending on the need. She needs access to appropriate oral medications include pain medication, nonsteroidal anti-inflammatory medications as needed.

Pain management for spinal conditions may be helpful.

This may include various kinds of injection, ablation, pain medication. This may also include injection to the basal joint of the right shoulder for flare-up.

Diagnostic studies in the form of MRI scan and CT scans, electrodiagnostic studies, and x-rays will be needed for any body part.

Again, all these recommendations applied to specific flare-ups of her condition and her monitoring of her medication.

Surgery is a possible outcome in terms of the cervical and lumbar spine, right hip, and both knees.

Spinal surgery may be needed particularly for lumbar spine.

Total knees usually last 15 to 20 years depending on how much wear there is, she may need revision or replacement.

Podiatry evaluation and treatment recommended by a podiatry should be available for the applicant's feet.

48. [redacted] Pain management note from Dr. [redacted]

Blood pressure is 164/92, pulse 59, no weight noted. Social history, PD with a client that she canceled. No other details. Under occupation is disabled. Divorced x2.

Diagnoses 1 through 15 are listed.

Treatment plan is intra-articular steroid shoulder injection bilaterally.

In treatment plan, cervical MRI discussed. The applicant will consider a CESI and may require surgery. Will see Dr. [redacted] next week. The applicant had a great relief with bilateral shoulder injections. She may be suffering from bursitis and tendonitis in addition to cervical complaints.

49. [redacted] Pain management note from Dr. [redacted]

The applicant continues treatment at Synovation. She had been prescribed 90 Norco 10/325 mg, Ultram 50 mg x60 each month. No longer on Xanax.

The applicant is status post TKR on the right by Dr. [redacted] at DRMC with uneventful recovery. No physical therapy at this time.

Positive RF, positive lichen planus.

Also diagnosed with pemphigoid, Dr. [redacted] emptied her lap band and refilled it partially. Will follow up with him in September when he is back from vacation.

Apparently Dr. [redacted] wants to remove the lap band and do a gastric sleeve. She is still trying to settle Workers' Compensation case. Other medications include losartan 50 mg q.d., gabapentin 600 mg, Ultram b.i.d., and Norco 10/325 mg two and a half tabs per day.

Her PTP is Dr. [redacted] PCP is Dr. [redacted] and [redacted]

The applicant is using CPAP nightly. There is reference to bilateral shoulder injections at last visit with great benefit. She apparently will have bilateral shoulder MRIs [redacted].

Comment regarding headaches, she has received Botox injections last Friday at Synovation. There have no followups with Dr. [redacted] of late. At last visit with him, Dr. [redacted] felt the residual complaints were related to the right hip. In the past, the applicant has been told that she has had bursitis and a labral tear.

On this visit, blood pressure is 187/76, pulse 103, no weight noted.

Diagnoses: Unchanged.

The applicant is given trigger point injections in the right trapezius muscle, Marcaine and Kenalog. Also occipital nerve block, right left greater occipital nerves. In treatment plan, the applicant did see Dr. [redacted] after last visit here. She will start physical therapy at [redacted] this week. He believes that both her neck and shoulders can be problematic. We will see what is going on after bilateral shoulder MRIs are done.

Bilateral cervical TP injections done today. She was able to raise her arms

above the head without difficulty. Continue current medications, no comment on work status.

DIAGNOSES

1. Hypertensive cardiovascular disease.
2. Atherosclerosis of mitral and aortic valves – nonindustrial.
3. Atherosclerosis of carotid arteries, abdominal aorta, and arterial circuit of lower extremity – nonindustrial.
4. Thyroid mass – nonindustrial.

DISCUSSION

Hypertensive cardiovascular disease.

Causation

The applicant has a history of major traumatic industrial orthopedic injuries which resulted in the need for surgical intervention and the applicant is scheduled for additional surgical intervention involving her neck in November [redacted]. As a result of stress and pain associated with her industrial orthopedic injuries, the applicant has developed severe hypertension with involvement of the heart in the form of left ventricular hypertrophy and diastolic dysfunction. The applicant's hypertensive cardiovascular disease is inadequately controlled and she requires more sophisticated evaluation of treatment. Accordingly on an expedited/urgent/immediate basis, I recommend referral to your network cardiologist for further evaluation and treatment of her inadequately controlled hypertension, which puts her at a considerable risk to develop a stroke and/or death. Please be sure to expedite the referral. The applicant is working with another employer.

Disability Status

At this time, there is temporary total or temporary partial disability applicable from the perspective of internal medicine.

Accordingly, the applicant has not reached MMI status because she requires further evaluation and treatment to control her heart problems related to high blood pressure.

I note that it will take approximately three months of intensive treatment by a cardiologist to stabilize her condition and to reach potential MMI/permanent stationary status.

After I receive the reports from the cardiologist and I am satisfied that the patient has reached MMI status, I will submit a final report.

Apportionment

Conclusion deferred.

Medical Treatment

As indicated, the applicant should have immediate referral to a cardiologist on an industrial basis for more intense management of her hypertensive cardiovascular disease. Future treatment will most likely include office visits at two-week intervals until her condition is stabilized. Thereafter, office visits may be stretched out to once every month to three months. However, I will add further discussion in my final report.

DISCLOSURE

This report is for medical-legal evaluation and/or treatment and is not a complete evaluation for non-occupationally-related medical reasons or for general health purposes. Only those symptoms which the signing physician believes have been reported or involved in the injury or alleged injury have been evaluated, diagnosed and commented upon. In relation to the general health of the patient herein, the patient has been notified or advised to seek further help and/or continue under the care of his/her personal physician on a private basis if and where this is indicated.

"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 I personally performed the evaluation of the patient and that, except as otherwise stated herein, the evaluation was performed and the face-to-face time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (5) of Section 139.2 or Section 5307.6 of the California Labor Code. In order to complete a comprehensive assessment of internal organ structures, my standard/usual evaluation includes: blood tests, lung test, urinalysis, and electrocardiogram. It has been my experience that patients may not be aware of all medical problems in dispute. Records may reveal internal medical problems which need to be resolved. In some instances, a dispute may arise concerning compensation for studies which may not appear appropriate for the type of alleged industrial injury. Under such circumstances, it is my usual policy to accept the decision of the Review Board of insurance carrier and accept reasonable disallowances for billed studies. Patients

suffering from internal medical injuries require laboratory studies, EKG, lung testing and other studies related to their claim. Where such studies could not be obtained on a lien basis, the studies will be completed at Dr. Majcher's lab and diagnostic clinic. In regard to any diagnostic testing performed under my supervision, wherever performed, I will assume authorization is granted unless I receive written notification of denial within ten calendar days from the date my report was mailed. The studies will be performed in my office. I will bill for these services per applicable Medical Fee Schedule. I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 and 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 any referred examination or evaluation.

Please be advised, the fees charged by this office exceed the official medical fee schedule in this matter. Such fees above the schedule are in accordance with Labor Code #5307.1. The explanation for the increased fees would be as follows.

1. Stanley J. Majcher, M.D., has been providing Workers' Compensation evaluation and treatment for 50 years and has treated thousands of patients for industrial injuries.
2. The fees charged do not exceed AOC/DA's usual and customary charges.
3. The fees are within the range of those charged by similar specialists within and around the local community.
4. The Economic aspects of an internal medical practice within a Workers' Compensation practice involves overhead expenses which include but are not limited to the need for qualified persons to conduct collection and make appearances before the board. There is also the overhead involved in the average amount of time between incurring costs and receipt of payment. The fees must be above the official medical fee schedule in order to maintain the medical practice.

Statement referable to reasonable cost of clerical expense necessary to produce this report as per California Statute 4628. The State of California Labor Code Statute 4628 entitled "Responsibilities of physician signing medical legal report" Paragraph (D) authorizes "Reasonable costs of clerical expense necessary to produce the report."

I further declare under penalty of perjury that the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies other than clerical preparations are as follows:

STAFF

Name:	**Qualifications:**
Yolanda Taylor Stephanie Flores Terri Cummings	Front office receptionists, including scheduling of patients and depositions.

Monique Sandoval Jennifer Del Franco Jennifer Flores	Certified medical assistants regarding phlebotomy, vital signs, lung spirometry, EKGs, and Holter monitoring.
Eryn Thompson Mark Mendoza Matt Mendoza	Certified echocardiologists, ultrasound technicians.
Arun Sanghavi	Laboratory consultant regarding technical aspects of laboratory data completion.
Monique Sandoval Stephanie Flores	Billing and collections.
Independent contractors	Billing/Accounting
Paul Hovsepian, M.D.	Salaried Cardiologist ($2,500 per month) to read over echocardiography studies and interpret Holter monitor studies. Cardiology consultant at his Alhambra office regarding consultations authorized by insurance carriers. Evaluations and billing are done by Dr. Hovsepian and his staff at his Alhambra office. There are no other financial arrangements with Dr. Hovsepian except for the monthly salary.
Transcriptionist	Independent contractor.
Monique Sandoval Jennifer Del Franco	Audits reports for typographical errors and ensures reports are submitted within compulsory guidelines.
Marley Majcher	Chief Executive Officer/Marketing Consultant.
Richard Steffann	Trained by Dr. Majcher for record reviews. Upon request by Dr. Majcher, Richard Steffann prepares abstracts of medical records for review of records regarding any patient concerns.
Stanley J. Majcher, M.D., F.A.C.P.	Reviews abstracts prepared by Richard Steffann for correction and insertion of any necessary details as applicable to patient evaluations. Board Certified in Internal Medicine specialist. Takes history and performs physical examinations. Interprets and renders opinions and conclusions on all diagnostic studies.

Reviews records and corrects any omissions or errors from record reviewer. Adds any other pertinent details.

Opinions and conclusions in all reports are completed solely by Dr. Majcher.

Dr. Majcher reviews all medical literature.

Staff members are not allowed to take histories or render any advice or opinions to patients.

In order to avoid ex parte issues, staff members interface with insurance carriers, attorneys, and interested parties, as necessary.

If you have any questions, please feel free to contact me.

Yours sincerely,

Stanley J. Majcher, M.D., F.A.C.P.

Signed in Los Angeles County this [redacted] Day of [redacted].

Stanley J. Majcher, M.D., F.A.C.P.

Board Certified in Internal Medicine
1028 East Walnut Creek Parkway, Suite C
West Covina, CA 91790-3072
626-919-5888 telephone; 626-919-5641 fax
Please send all correspondence to the above address

[redacted]

SAMPLE REPORT #2

[redacted]

Patient: [redacted]
Date of Birth:
Claim No.:
EAMS Case No.:
Date of Injury:
Employer:
Date of Evaluation:

INITIAL INTERNAL MEDICINE ONE TIME CONSULTATION REPORT (AUTHORIZED)

Dear Gentlepersons:

As requested, the patient was evaluated at my office.

This **INITIAL** medical examination **CONSULTATION** report is being billed as CPT Code:

99205
99358
99359

As requested, I have reviewed the following 1 inch of records.

I have spent:

A. 1 hour face to face time.
B. 1 hour reviewing the records.
C. 1 hour organizing, formulating an opinion, dictating and editing this report and
D. 0 hours reviewing medical literature
E. for a total of 3 hours.

SUMMARY OF FINDINGS REGARDING BILLING

99205
99358
99359

SUMMARY OF FINDINGS REGARDING BILLING – 99205, 99358 and 99359

1. Face-to-face time: 90 minutes.

2. Non face-to-face time spent reviewing the records: 90 minutes.

a.) 60 minutes, or initial hour of non-face-to-face time, per 99358

b.) 30 minutes of extended non face-to-face prolonged service. Per 99359, 1 units.

3. Type of history: comprehensive.

4. Elements: multiple.

5. Review of systems: complete and exceeds ten.

6. Physical examination: comprehensive involving general, multi-system exam, and complete examination of multiple organ systems.

7. Medical decision mechanism: highly complex; presenting problems are of moderate to high severity.

CPT code 99205: Requires these 3 key components: a comprehensive history; a comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. ***Typically, 60 minutes are spent face-to-face with the patient and/or family.***

CPT code 99358: Prolonged evaluation and management service before and/or after direct patient care; ***first hour.*** Per CMS guidelines, at least half of the typical time is required to bill this code. ***At least 30 minutes of non-face-to-face time has been spent regarding this patient. See below.***

> Per MLN Matters Number: MM5972, published by CMS, "Providers should not separately report prolonged service of **less than 30 minutes total duration** on a given date because the work involved is included in the total work of the E&M codes.

CPT code 99359: ***Each additional 30 minutes*** in addition to code 99358 for prolonged service (add-on code to 99358). Per CMS guidelines, at least half of the typical time is required to bill this code, or 15 minutes in addition to the time required for 99358.

I have spent 1 hours reviewing the records, 1 hour organizing, formulating an opinion, dictating and editing this report and 0 hour reviewing medical literature for a total non-face-to-face time of 2 hours. This is billed at 1 unit of 99358 and 2 units of 99359.

SOURCE OF FACTS

Patient, results of medical evaluation, and any records submitted.

INJURED BODY PARTS

Referral is not specific regarding internal medical issues.

The patient related a background of:
1. Type I diabetes.
2. Gastrointestinal issues (upper).

JOB DESCRIPTION/MECHANISM OF INJURY AS RELATED BY THE PATIENT

The patient is a [redacted]-year-old male who had been hired in March or [redacted] a press operator.

He noted orthopedic injury on January [redacted] but denied any surgical intervention.

i. Type I Diabetes– diagnosis has been established at age 13. Medications prior to the date of injury were not prescribed because he did not have finances to purchase insulin which

is mandatory since it is type I diabetes that results in self destruction whereby he cannot produce insulin.

He estimates insulin had not been provided at least three years prior to the date of injury.

The issues are a little complicated because the patient indicates that a physician whose name he could not recall told him he did not require insulin and the physician recommended oral medication in the form of metformin and glyburide. Note, insulin is mandatory in type I diabetes.

The patient does not have a physician for diabetes.

He did have a medical evaluation two years ago, but he is uncertain regarding the results.

To date he is still not receiving insulin.

ii. Upper gastrointestinal issue. His pre-injury weight is [redacted] pounds and as a result of a certain degree of inactivity associated with his orthopedic injuries his weight has increased to [redacted] pounds. He has noted nausea and vomiting, but never vomited blood. He has noted epigastric and right upper quadrant pain. He has also noted pain in the midchest area.

iii. Lower gastrointestinal issue. Four to five months ago, he had an episode of rectal bleeding. He discontinued the medications, the names of which he cannot not recall and the rectal bleeding discontinued, although this does not exclude a significant organic issue.

PAST HISTORY

Type I diabetes.

ALLERGIES

None.

CURRENT MEDICATIONS

None.

HABITS

Alcohol: Negative.
Tobacco: Negative.

FAMILY HISTORY

Diabetes mellitus:	Both parents suffer from type II diabetes.
Hypertension:	Positive for father, he is uncertain.

Negative for hereditary diseases.

PHYSICAL EXAMINATION

General:

Height:	[redacted] feet [redacted] inches
Weight:	[redacted] pounds
Blood pressure:	102/78
Pulse:	101
Pulse oximetry:	Normal on room air at 97%
Respirations:	20

The patient is an alert, active, and overweight male in no apparent acute distress.

Head: No evidence of trauma.

Neck: Thyroid not enlarged; no bruits.

Skin: No significant rashes, eruptions, ulcerations, erythema, "spiders," or telangiectasia.

Lymph nodes: No clinically significant abnormalities.

Eyes: Vision grossly intact; pupils normal; no icterus; fundi negative; extraocular movements normal.

Nose: Negative.

Oral cavity: Negative.

Lungs: No abnormal sounds; clear to percussion.

Heart: Size normal. No murmurs; sounds are normal; no friction rubs.

Pulses: The following are normal: carotid, radial, bronchial, femoral, popliteal, posterior tibial, and dorsalis pedis.

Extremities: No abnormal swelling, tenderness, tophi, ulcers, edema, clubbing or cyanosis.

Abdomen: No abnormal tenderness, no masses palpable, no organ enlargement, bowel sounds normal, no evidence of hernia.

Neurological: Deep tendon reflexes are normal; no pathological reflexes; sensation normal; examination is essentially negative.

STANDARD/SPECIAL INTERNAL MEDICAL DIAGNOSTIC STUDIES

Not completed; authorization pending. See my comments.

REVIEW OF RECORDS (CD, 147 pages, Chart #1)

1. [redacted] Modified duties note from Dr. [redacted]. Please note that there are no records available of internal medicine nature available.

2 [redacted] PR-2 report again from [redacted] Medical Center, Dr. [redacted]

Blood pressure is 120/70, pulse 80, no weight noted. The applicant is to start physical therapy. He has enough medications, no details. Work restrictions are unchanged. There are several printouts from [redacted] Medical Center that cannot be read.

3. [redacted] DWC form RFA from Dr. [redacted] Again additional physical therapy.

4. [redacted] Partial PR-2 report from Dr. [redacted]

Blood pressure is 100/80. The applicant called out yesterday because he could not get out of bed.

Diagnosis: Unchanged.

5. [redacted] Utilization reviewed note from [redacted] per Dr. [redacted] request for MRI of the lumbar spine. Medication note apparently not approved for Flexeril.

6. [redacted] PR-2 report from Dr. [redacted]

Blood pressure is 130/80. He has not yet started physical therapy.

7. [redacted] Physical therapy daily report from [redacted] Medical Center. On the first visit, lumbosacral spine strain. Lumbosacral spine myospasm.

8. [redacted] Additional DWC form RFA from Dr. [redacted] for transfer care to ortho.

9. [redacted] MRI of the lumbar spine without contrast from Dr. [redacted]

Impression: Lower lumbar spine multilevel disc bulges resulting in spinal canal and neural foraminal compromise. In findings, L3-L4, there is a broad-based disc bulge noted up to 4.5 mm. Mild bilateral facet hypertrophy noted. There is mild spinal canal narrowing visualized. L4-L5, there is a broad-based disc bulge measuring up to 5 mm slightly extended to the right. There is mild bilateral facet hypertrophy noted. There is mild to moderate spinal canal stenosis and mild bilateral neural foraminal stenosis.

L5-S1, there is a central disc bulge measuring up to 6 mm. Mild bilateral facet hypertrophy noted. There is ventral impression on the thecal sac with mild spinal canal narrowing visualized. Mild bilateral neural foraminal stenosis also visualized.

10. [redacted] PR-2 report from Dr. [redacted]

Blood pressure is 130/70. No weight noted. The applicant is waiting to hear for ortho appointment. Insurance sent him back here for recheck. It has been five weeks since he has not been seen.

The applicant states he called off work because his pain was too much. He wants a refill on his medications.

Diagnosis: Unchanged. Rx for Tylenol given. Ortho transfer care has been approved, appointment set for 05/01/20. Modified duties if available. A series of billing statements and claims information from Abbott and Immediate Care Center.

11. [redacted] Initial orthopedic consultation from Dr. [redacted]

Date of injury [redacted]

In history of injury here, [redacted] he came, he was pushing a 700-pound roll of paper on to a ramp when due to lack of force it rolled back down. He felt a sharp pain in the low back.

Currently, he has had x-rays and MRI but does not have physical therapy, acupuncture, massage treatment, or chiropractic therapy.

The applicant denies any significant past medical history of injury or disabilities to the back prior to [redacted]. Also of note, previous medical history, he denies a history of high blood pressure, diabetes, or cardiac, pulmonary, or GI disorders.

He is not presently taking any medications. He has tried ibuprofen and Medrol Dosepak. No muscle relaxants or narcotic pain medication.

In this history, the applicant smokes a pack of cigarettes per week. Family history is noncontributory. Review of systems is otherwise negative.

On exam, blood pressure is 140/80, pulse 78, weight is at [redacted] pounds. In record review is an undated MRI of the lumbar spine, x-rays of the lumbar spine.

Assessment and Plan:

1. Lumbar disc displacement, mild.
2. Lumbar spinal stenosis.
3. Lumbar degenerative disc disease.
4. Continuous trauma of lumbar spine, industrial.

The applicant is given a prescription for Celebrex 200 mg two daily for two weeks, then one daily. Also soma 350 mg. Modified duties if available. DWC form RFA is complete.

12. [redacted] Additional series of previously reviewed records from Dr. [redacted] office.

13 [redacted] DWC form RFA from Dr. [redacted] additional physical therapy and acupuncture 2x6. Therapeutic massage therapy.

14. [redacted] Utilization review note from [redacted] with Dr. [redacted] request for acupuncture. Authorization [redacted] for pain management consultation, massage therapy, lumbar spine physical therapy, acupuncture.

15. [redacted] Handwritten initial physical therapy evaluation at [redacted] Rehab Agency referred by Dr. [redacted]

16 [redacted] Orthopedic followup from Dr. [redacted]

On exam, blood pressure is 144/88, pulse 104, weight at now [redacted] pounds.

Diagnosis: Unchanged.

In discussion, the applicant is not responding well to our initial treatments. He required pain management consultation with Dr. [redacted] to evaluate and treat and provide lumbar spinal epidural injections. He is given prescription for Flexeril 10 mg. He is TTD.

17. [redacted] DWC form RFA from Dr. [redacted]

Pain management with Dr. Shea for evaluation and treatment with lumbar steroid epidural injections.

18. [redacted] Noncertification note per Dr. [redacted] request for lumbar epidural injection.

19. [redacted] Followup note from Dr. [redacted]

Pain management was requested; however, this is denied.

At this point, the applicant is the same if not worse. On exam, blood pressure is 138/86, pulse 88, now weight up to [redacted] pounds.

Diagnoses one through four unchanged.

The applicant will require urgent referral to orthopedic spine surgeon MPN as he has worsening radiculopathy. He will be given an appointment to follow up here on [redacted] however, if he is seeing the spine surgeon which he should have been by this time, there would be no need for him to return here. He is TTD per Dr. [redacted]

20. [redacted] DWC form RFA from Dr. [redacted] Urgent referral to orthopedic spine surgeon of MPN.

21. [redacted] Initial orthopedic consultation-AME outside record review from Dr. [redacted]

The applicant began his employment with the company as a rewind operator in approximately March [redacted] He states he was placed off work by Dr. [redacted] at the clinic in [redacted]

The applicant last worked approximately February [redacted].

Chief complaints are pain located in the low back with radiation down the right leg to the right ankle, occasional pain down the left leg to the left ankle.

In history of injury, [redacted] he states he was pushing a large paper roll approximately 4 feet high, weighing approximately 600 pounds.

The applicant states he began to push the roll up an incline when the roll began to roll back.

The applicant pushed himself against it to prevent it from rolling down. He states he felt "a pop" in the low back causing shooting pain down the back.

He reported the injury to his supervisor and was sent immediately to the company clinic in La Mirada. He was prescribed "painkillers" and given work restrictions.

He was seen once a week at the company clinic for approximately two months. He was then ordered an MRI of the lumbar spine, he was placed TTD.

The applicant was not happy with the care he was receiving and requested to change doctors. He was referred to chiropractor, [redacted] in May [redacted] for his low back.

This doctor apparently reviewed the previous lumbar spine MRI, suggested he undergo epidural steroid injections.

He also states that authorization for the injections was not approved, and he should be considered to undergo low back surgery.

Lumbar epidural injections for the low back were requested but not approved. He was then referred to physical therapy and also attended acupuncture for three weeks.

He states that this made his condition worse, thus he discontinued it.

Currently, he last saw Dr. [redacted] in August [redacted] He did not hear from the doctor; therefore, he did not return.

His attorney in October [redacted] referred him to Dr. [redacted] He was then referred to pain management, Dr [redacted] to discuss epidural injections.

The applicant also indicates he had diabetes mellitus since approximately age 13. Epidural injections are a risk factor if his sugar is not controlled.

The applicant is not taking any medication for diabetes since he does not have any money to pay for the medication.

Certainly medications have been recommended. He also reports the NSAID medication give him stomach pain. No other details.

In past medical history, the applicant is listed as [redacted] feet [redacted] inches, [redacted] pounds. He smokes two cigarettes daily. No medications listed.

X-rays of the lumbar spine were reviewed.

Dr. [redacted] has reviewed 255 pages of outside records.

One initial chronological Workers' Compensation medical summary.

Findings:

1. [redacted] approximately date of onset diabetes type 1 at age 13.
2. [redacted] date of injury, low back area lifting spool of wire weighing 100 pounds.
3. [redacted] doctor's first report of injury from Dr. [redacted] with a history of injury at [redacted] Low back complaints.

Years ago had the same problem and was treated. Diagnosis at that time was lumbar strain, radiculitis.

1. [redacted] x-rays of the lumbar spine from Dr. [redacted] at emergency room with minimal degenerative changes at L4 through S1.
2. [redacted] Dr. [redacted] return to work with restrictions and no lifting greater than 5 pounds.
3. [redacted] physical therapist stating doing fine until here it states trying to lift a roll of heavy wires at work, sudden low back pain.
4. [redacted] back support and work restrictions.
5. [redacted] lumbar strain resolved, return to full duties [redacted]. No ratable disability.

6. March [redacted] approximately date of hire at [redacted] Inc.
7. [redacted] Dr. [redacted] history of injury the same date, low back pain, pushing a 200-pound roll of paper
8. [redacted] x-rays from Dr. [redacted] Lumbar spine, minimal degenerative changes. X-rays, lumbar spine at L4-L5.
9. February [redacted] approximately last day of work according to the applicant in today's evaluation [redacted] Positive straight leg raising bilaterally, atrophy of the left thigh, awaiting LESI, diabetic condition unknown, exogenous obesity, not taking medications at this time, awaiting LESI, and need of internal medicine evaluation prior to LESI.
10. [redacted] worse than prior visit with low back pain to right leg. Still awaiting MRI. Modified duties if available.
11. [redacted], MRI of the lumbar spine from Dr. [redacted].
12. [redacted] initial orthopedic consultation with Dr. [redacted] Listed as a continuous trauma to lumbar spine industrial, mentioned on [redacted] no mention of prior injury.
13. [redacted], Dr. [redacted] has recommended urgent referral to orthopedic spine surgeon within the MPN.
14. [redacted] claim for injury [redacted] to the lumbar spine at [redacted] Inc.
15. [redacted] modified duties if available.
16. [redacted] has RFA for gabapentin, Prevacid, and TENS unit.

Medical diagnosis, derivative current exam, [redacted]-AME evaluation with a history of onset diabetes type 1 at age [redacted], multilevel disc disease of the lumbar spine with radiculopathy right greater than left lower extremity.

In discussion, in today's evaluation, the applicant was evaluated [redacted] was pleasant and cooperative.

He did not give a history of injuries prior to [redacted]

The applicant clearly had some prior history as noted above. Did have a copy of MRI typewritten report but the disc itself could not be evaluated. They were unable to copy this disc because it requires a server connection.

The applicant's orthopedic condition will be discussed below, but at this point, he needs total labs. He also needs electrodiagnostic study of the lower extremities. Dr. [redacted] had advised he see internal medicine specialist prior to LESI which is a reasonable thing to do. In the meantime, he is TTD. No additional medications listed.

22. [redacted] Electrodiagnostic study of the lower extremities from Dr. [redacted] were reviewed. This is found to be abnormal with active bilateral L4-L5 and L5-S1 radiculopathy. There is also mild evidence for demyelinating sensory peripheral neuropathy as well. Several reports from February or January [redacted] from Dr. [redacted] are noted.

23. [redacted] DWC form RFA from Dr. [redacted] again for MRI of the lumbar spine without contrast.

24. [redacted] Review of an MRI of the lumbar spine from Dr. [redacted]

Diagnostic summary 1 to 22 are listed.

In discussion, the applicant's blood sugars are grossly abnormal. He needs to be seen by an internist and have his diabetes rendered under control prior to any epidural injections. Again in discussion, objectively, he has a grossly abnormal MRI of the lumbar spine dated [redacted] Objectively, Dr. [redacted] is unable to print black and white reproduction of this. Objectively, the study was done almost a year ago. The new MRI from [redacted] again reports three-level disc disease with desiccation and significant disc protrusion at the lowest three levels, the worst being the lowest level.

Objectively, EMG likewise abnormal suggesting radiculopathy.

Disability status not permanent and stationary, the applicant with hyperglycemia, needs to have his diabetes brought under control and will be a candidate for epidural injections at that time. In the meantime, he is considered TTD or modified duties if available.

AOE/COE is established for the injury of [redacted]

25. [redacted] Supplemental final permanent and stationary AME report, outside record review from Dr. [redacted] In review of records is a [redacted], lab review. Blood sugar is grossly out of order at 264. White count was elevated, hemoglobin and hematocrit are also elevated. Hemoglobin was 17.5 with the normal being up to 17.1 in this lab. Hematocrit was 50.7, normal being 50 in this lab. BUN and crit were normal, electrolytes normal. Sed rate was normal.

DIAGNOSES

1. Type I diabetes.
2. Gastroesophageal reflux disease/rule out esophagitis/gastritis secondary to administration of nonsteroidal anti-inflammatory drugs for orthopedic injuries.
3. Rectal bleeding, cause to be determined.

DISCUSSION

Issues are complicated. Accordingly kindly note the following recommendations:

1. Kindly refer treating physicians evaluate his current status regarding type I diabetes and administration of insulin is necessary in type I diabetes since patients with type I diabetes have no insulin production and require insulin.

   The patient has gained weight and has sustained orthopedic injuries, which commonly aggravate underlying diabetes. The referral should be made on an industrial basis.

2. Kindly refer the applicant to a network gastroenterologist to complete upper gastrointestinal endoscopy and colonoscopy to obtain objective findings regarding the patient's gastrointestinal issue. The applicant has a history of orthopedic injuries which resulted in treatment with nonsteroidal anti-inflammatory drugs, which commonly cause type of subjective abnormalities noted in the patient's background.

In order for me to complete my final opinions and conclusions, kindly note the following which are necessary:

1. Submit the reports from the treating physician regarding diabetes.
2. Submit the reports from the gastroenterologist regarding upper gastrointestinal endoscopy and colonoscopy.
3. Submit payment for the current consultation. The issues are very complicated. The issue is particularly complicated in view of the fact he has type I diabetes and amazingly he is surviving despite treatment without insulin.

DISCLOSURE

This report is for medical-legal evaluation and/or treatment and is not a complete evaluation for non-occupationally-related medical reasons or for general health purposes. Only those symptoms which the signing physician believes have been reported or involved in the injury or alleged injury have been evaluated, diagnosed and commented upon. In relation to the general health of the patient herein, the patient has been notified or advised to seek further help and/or continue under the care of his/her personal physician on a private basis if and where this is indicated.

"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 I personally performed the evaluation of the patient and that, except as otherwise stated herein, the evaluation was performed and the face-to-face time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (5) of Section 139.2 or Section 5307.6 of the California Labor Code. In order to complete a comprehensive assessment of internal organ structures, my standard/usual evaluation includes: blood tests, lung test, urinalysis, and electrocardiogram. It has been my experience that patients may not be aware of all medical problems in dispute. Records may reveal internal medical problems which need to be resolved. In some instances, a dispute may arise concerning compensation for studies which may not appear appropriate for the type of alleged industrial injury. Under such circumstances, it is my usual policy to accept the decision of the Review Board of insurance carrier and accept reasonable disallowances for billed studies. Patients suffering from internal medical injuries require laboratory studies, EKG, lung testing and other studies related to their claim. Where such studies could not be obtained on a lien basis, the studies will be completed at Dr. Majcher's lab and diagnostic clinic. In regard to any diagnostic testing performed under my supervision, wherever performed, I will assume authorization is granted unless I receive written notification of denial within ten calendar days from the date my report was mailed. The studies will be performed in my office. I will bill for these services per applicable Medical Fee Schedule. I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 and 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 any referred examination or evaluation.

Please be advised, the fees charged by this office exceed the official medical fee schedule in this matter. Such fees above the schedule are in accordance with Labor Code #5307.1. The explanation for the increased fees would be as follows.

1. Stanley J. Majcher, M.D., has been providing Workers' Compensation evaluation and treatment for 50 years and has treated thousands of patients for industrial injuries.
2. The fees charged do not exceed AOC/DA's usual and customary charges.
3. The fees are within the range of those charged by similar specialists within and around the local community.
4. The Economic aspects of an internal medical practice within a Workers' Compensation practice involves overhead expenses which include but are not limited to the need for qualified persons to conduct collection and make appearances before the board. There is also the overhead involved in the average amount of time between incurring costs and receipt of payment. The fees must be above the official medical fee schedule in order to maintain the medical practice.

Statement referable to reasonable cost of clerical expense necessary to produce this report as per California Statute 4628. The State of California Labor Code Statute 4628 entitled "Responsibilities of physician signing medical legal report" Paragraph (D) authorizes "Reasonable costs of clerical expense necessary to produce the report."

I further declare under penalty of perjury that the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies other than clerical preparations are as follows:

STAFF

Name:	**Qualifications:**
Yolanda Taylor Stephanie Flores Terri Cummings	Front office receptionists, including scheduling of patients and depositions.
Monique Sandoval Jennifer Del Franco Jennifer Flores	Certified medical assistants regarding phlebotomy, vital signs, lung spirometry, EKGs, and Holter monitoring.
Eryn Thompson Mark Mendoza Matt Mendoza	Certified echocardiologists, ultrasound technicians.
Arun Sanghavi	Laboratory consultant regarding technical aspects of laboratory data completion.
Monique Sandoval Stephanie Flores	Billing and collections.
Independent contractors	Billing/Accounting
Paul Hovsepian, M.D.	Salaried Cardiologist ($2,500 per month) to read over echocardiography studies and interpret Holter monitor studies. Cardiology consultant at his Alhambra office regarding consultations authorized by insurance carriers. Evaluations and billing are done by Dr. Hovsepian and his staff at his Alhambra office. There are no other financial arrangements with Dr. Hovsepian except for the monthly salary.
Transcriptionist	Independent contractor.
Monique Sandoval Jennifer Del Franco	Audits reports for typographical errors and ensures reports are submitted within compulsory guidelines.

Marley Majcher	Chief Executive Officer/Marketing Consultant.
Richard Steffann	Trained by Dr. Majcher for record reviews. Upon request by Dr. Majcher, Richard Steffann prepares abstracts of medical records for review of records regarding any patient concerns.
Stanley J. Majcher, M.D., F.A.C.P.	Reviews abstracts prepared by Richard Steffann for correction and insertion of any necessary details as applicable to patient evaluations. Board Certified in Internal Medicine specialist. Takes history and performs physical examinations. Interprets and renders opinions and conclusions on all diagnostic studies. Reviews records and corrects any omissions or errors from record reviewer. Adds any other pertinent details. Opinions and conclusions in all reports are completed solely by Dr. Majcher. Dr. Majcher reviews all medical literature.

Staff members are not allowed to take histories or render any advice or opinions to patients.

In order to avoid ex parte issues, staff members interface with insurance carriers, attorneys, and interested parties, as necessary.

If you have any questions, please feel free to contact me.

Yours sincerely,

Stanley J. Majcher, M.D., F.A.C.P.

Signed in Los Angeles County this 20th Day of December, 2021.

June 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

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

FOR: July 6, 2022, Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
SAMUEL A. BERKMAN, M.D. – ONCOLOGY

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 Samuel A. Berkman, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

The Disability Retirement Services Division engaged Consultative Examination Services, Inc. (CES) to discuss potential candidates for the LACERA Panel of Examining Physicians. CES manages a panel of board-certified physicians specializing in Medical-Legal and Workers' Compensation Evaluations. The CES network includes expertly trained and highly skilled physicians within a variety of specialties.

Samuel A. Berkman, M.D. is Board Certified in Internal Medicine, Oncology, and Hematology. He received his medical degree from Tufts University 1971 and completed internal medicine at Cedars-Sinai Medical Center and fellowships at the University of California, Los Angeles, and National Institutes Health. Dr. Berkman has 30 years of experience performing medical legal evaluation 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. Staff will also provide an overview of the Quality Control Questionnaire process and procedures.

On June 8, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Samual A. Berkman, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Samuel A. Berkman, 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 19, 2022
Phys c an Name: samuel a berkman	Group Name: Consultative Examination Services, Inc.
Pr mary Address: 1) 344 25th St, Santa Monica, CA 90402 2) 9001 Wilshire Blvd, Ste 200, Beverly Hills, CA 90211	
Pr mary Contact: Moses Hernandez	T t e: CEO
Te ephone: (626) 513-0415 Fax: (626) 513-4095	Ema : [redacted]
Secondary Address: N/A	
Te ephone: (626) 513-0415 Fax: (626) 513-4095	Ema : [redacted]

PHYSICIAN BACKGROUND	
F e d of Spec a ty: Board Cert f cat on ☒Yes ☐No	Subspec a ty: Board Cert f cat on ☒Yes ☐ No
L cense # G23110 Exp rat on Date: 12/31/2023	
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	10	Treatment	80
IME	20	Eva uat ons	5
QME	10	Research	5
Workers' Compensation Eva uat ons	0	Teach ng	10
D sab ty Eva uat ons	10		100 %
Med-Lega Reports	30		

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: Sam Berkman	T t e: M.D.
Phys c an S gnature: Sam Berkman (Jan 19, 2022 13:09 PST)	Date Jan 19, 2022

You may attach additional pages if necessary.

Rev sed: 12/8/21

SAMUEL A. BERKMAN, M.D., F.A.C.P.
9001 WILSHIRE BLVD, SUITE 200
BEVERLY HILLS, CALIFORNIA 90211

HEMATOLOGY/MEDICAL ONCOLOGY INTERNAL MEDICINE

MEDICAL SCHOOL:		Tufts University
INTERNSHIP: 1971-1972		Cedars-Sinai Medical Center Los Angeles, CA
RESIDENCY: 1972-1974		Cedars-Sinai Medical Center Los Angeles, CA
FELLOWSHIP: 1974-1976		University of California, Los Angeles Hematology
FELLOWSHIP: 1976-1978		National Institutes Health, Medical Oncology Bethesda, Maryland
SPECIALTY BOARDS:		Certified Internal Medicine 1974 Certified Medical Oncology 1979 Certified Hematology 1980 Recertified Internal Medicine 1980
AWARDS:	1980-1986	Outstanding Clinical Faculty Teachers Department of Medicine, UCLA
	2016	Outstanding Reviewer Annals of Internal Medicine

SOCIETY MEMBERSHIPS:
Medical and Scientific advisory board- National Blood Clot Alliance
Fellow, American College of Physicians
American Medical Association
American Society of Hematology
International Society of Thrombosis and Hemostasis
International Society of Clinical and Applied Hemostasis, Thrombosis and vascular Medicine

Faculty- North American Thrombosis Forum
Member Anticoagulant Forum

ACADEMIC APPOINTMENTS:

Clinical Professor of Medicine, UCLA Medical Center Cal. License G-23110

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[redacted]

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t: 800.636.3926
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f: 206.623.4956

[redacted]

SAMPLE REPORT #1

[redacted]

Re:
Claim Number:
Date of Disability: [redacted]
Date of Birth:
MCN Number:

Dear

Thank you for allowing [redacted] to schedule an independent medical evaluation on [redacted]. The following is a report of the examination performed on December 14, [redacted]. [redacted], MD, prepared and dictated this report.

The opinions expressed in this report are those of the provider, and do not reflect the opinions of MCN. The examinee was informed that this examination was at the request of [redacted], that a written report would be sent to that agency, and that the examination was for evaluative purposes only. Furthermore, the examinee was informed that the purpose of the examination was to address specific injuries or conditions, as outlined by the requesting party, was not meant to constitute a general medical examination, and is not a substitute for seeking medical care from her personal provider. The examinee was also informed that during the examination she would not be required to engage in any physical maneuvers beyond what she could tolerate, or which she felt were beyond her limits, or could cause physical harm or injury.

The dictated report is as follows:

HISTORY / RECORD REVIEW

This is a -year-old woman, whose first date of limitation was July 30, [redacted], when she developed abdominal discomfort, and had surgery, and was diagnosed with an ovarian carcinoma involving the left ovary. There was also a uterine fibroid. She had a total abdominal hysterectomy and bilateral salpingo-oophorectomy performed.

She was given chemotherapy; however, it only lasted through December because she developed a peripheral neuropathy. The neuropathy got worse, and her oncologist stopped all treatment. It has not been resumed yet. The claimant has not had any scans to see if there is any recurrent disease.

Her neuropathy, however, is staying about the same. It basically involves mainly the lower extremities, particularly the feet, in a stocking-glove distribution. She states that it is not so much pain, but numbness and tingling; however, it impacts her balance. She has had one fall;

however, did not hurt herself terribly. She has had several near falls. She also experiences a sense of instability after standing for a very short period.

She is an Administrative Assistant for the Corporation, and her work involves going up several flights of stairs. She does not have to carry very heavy objects. She has been working over the last year or so from home. She works four hours a day, five days a week. She is very happy with this arrangement.

There is also another problem with the neuropathy, in that she does not have good sense of connection with the brake pedal or the gas pedal. This makes her a bit of a risk for an automobile accident.

Right now, she is very content with the situation as it is, working four hours a day, five days a week, and she says she likes the work, and wants to continue the work.

She takes other medications, including Neurontin and hydrochlorothiazide.

In her records, which were reviewed, there were no visits with any doctors, only Work Status Reports. There was one on September 10, [redacted], from Dr. z, who examined her, and put her on disability until September 30, [redacted]. There was another one from Dr. , from October 1, [redacted]. He put her on disability through January 31, [redacted]. Again, Dr. put her on disability from July 2, [redacted], to September 13, [redacted].

There are no reports in the records of any CT scans or any nerve conduction studies or EMGs to document the severity of the neuropathy.

PAST MEDICAL HISTORY

Her past medical history is otherwise significant. She has hypertension, and has the peripheral neuropathy.

REVIEW OF SYSTEMS

Head: No headache, seizure, or syncope.

Eyes: No amaurosis or blurring.

Ears: No tinnitus or hearing loss.

Throat: No dysphagia.

Cardiorespiratory: No chest pain or shortness of breath.

GI: No nausea, vomiting, diarrhea, or melena.

GU: No hematuria or dysuria.

Endocrine: No heat or cold intolerance.

Neurologic: No numbness or tingling.

PHYSICAL EXAMINATION

A well-developed, well-nourished female. She is feet inches, and weighs pounds. Blood pressure: . Pulse: . Respirations: .

Skin: No ulcerations or nevi.

Nodes: No enlargement.

Disks: Flat.

Throat: Clear.

Lungs: Clear.

Heart: Normal sinus rhythm.

Abdomen: She has got a hernia on the right side of the lower abdomen. No masses. No tenderness on deep palpation.

Extremities: No cyanosis, clubbing, or edema. She has decreased position sense, and a positive Romberg sign, on cerebellar testing and nerve conduction testing.

IMPRESSION AND RECOMMENDATIONS

The following is in response to the questions in your cover letter.

1) *Please refrain from using the word "patient" in reference to the individual under examination. Please refer to this individual as "claimant" in your report/dictation.*

   Done.

2) *Please add the following statement to your report: "I've reviewed all the medical information that was provided to Cigna on behalf of the customer."*

   I've reviewed all the medical information that was provided to Cigna on behalf of the customer.

3) *Based on the medical records provided and the IME performed, please have IME ONCOLOGY physician complete a PAA form outlining the customer's functional capabilities. Please be sure to explain your rationale for any restrictions given.*

   I will give my impression and recommendations. My assessment is that this claimant has a peripheral neuropathy from the chemotherapy she received for ovarian cancer. It is most likely cisplatin-induced. It is possible she got vincristine or vinblastine, but I doubt it, given that it was ovarian cancer. It made sense that they stopped the treatment.

The biggest concern that comes from this is its effect on her ability to drive, and the impact her feet make with the brake pedal and the gas pedal. Because of this, and she is working from home, I suggest she continue to work from home. She is happy to do this. If you wish her to increase her hours from doing that, she does not say she is against that. In any event, she enjoys her work, and is happy to continue this situation as is. She should not drive a car to work because she could get into a serious automobile accident. If she were to be driven to work, I would say that she should not stand for more than 15 minutes at a time, or walk for more than 15 minutes at a time, and would have to avoid any type of stair climbing, bending, and kneeling. She could grasp overhead objects 100% of the time, as her arms are not affected by this.

All conclusions in this report are solely the opinions of the author. There is no conflict of interest.

[redacted] *selection/retention of the author for this consultation and the compensation paid to the author is not based on support or nonsupport of impairment.*

There is no doctor/provider-patient treatment relationship.

All conclusions are advisory only, independently developed by the author, and based upon the best professional judgment of the examiner considering all the data available at the time of preparation of this report.

All opinions and conclusions are based on a reasonable degree of professional judgment, as absolute predictions are not possible.

[redacted] *does not make claim decisions and is not informed of any claim decisions.*

Samuel A. Berkman, MD
Medical Oncology, Board Certified
License Number: G00023110

Physical Ability Assessment

Life Insurance Company of North America
Connecticut General Life Insurance Company
Cigna Life Insurance Company of New York
Great-West Healthcare Administered by Cigna

Cigna

We are evaluating a disability claim for our customer and need to determine functional impairment. Please check the boxes corresponding to his/her level of physical functioning. **Please submit any and all medical documentation, including documented observations, physical exam findings and functional assessments. We appreciate your prompt response to this request.**

Customer Name _____ Date of Birth [redacted]

ICD codes(s): C-56.2

Your assessment of our customer's physical abilities is based on *(check all that apply)*:

- ☐ Customer's report
- ☑ Observation
- ☑ Examination
- ☑ Your functional assessment
- ☐ A formal functional capacity evaluation (FCE)
- ☐ A diagnosis that implies an increased risk of harm requiring physician imposed work activity restrictions

_____

_____

_____

Throughout an 8-hour workday, to the extent that positional changes are necessary, with rest breaks and meal breaks at appropriate intervals, he or she can tolerate the following activities for the specified durations:

		Constantly: > 5.5 Hrs/Day > 2/3 of the Day	Frequently: 2.5 - 5.5 Hrs/Day 1/3 - 2/3 of the Day	Occasionally: Up to 2.5 Hrs/Day Up to 1/3 of the Day	0 Hours	Check if supported by clinical findings	Does Not Apply to Diagnosis
Sitting:		☑	☐	☐	☐	☐	☐
Standing:		☐	☐	☑	☐	☐	☐
Walking:		☐	☐	☑	☐	☐	☐
Reaching:	Overhead	☑	☐	☐	☐	☐	☐
	Desk Level	☑	☐	☐	☐	☐	☐
	Below Waist	☑	☐	☐	☐	☐	☐
Fine Manipulation:	Right:	☑	☐	☐	☐	☐	☐
	Left:	☑	☐	☐	☐	☐	☐
Simple Grasp:	Right:	☑	☐	☐	☐	☐	☐
	Left:	☑	☐	☐	☐	☐	☐
Firm Grasp:	Right:	☑	☐	☐	☐	☐	☐
	Left:	☑	☐	☐	☐	☐	☐

	Constantly: > 5.5 Hrs/Day > 2/3 of the Day	Frequently: 2.5 - 5.5 Hrs/Day 1/3 - 2/3 of the Day	Occasionally: Up to 2.5 Hrs/Day Up to 1/3 of the Day	0 Hours	Check if supported by clinical findings	Does Not Apply to Diagnosis
Lifting: Negligible Amount - 10 lbs.	☐	☑	☐	☐	☐	☐
11-20 lbs.	☐	☐	☑	☐	☐	☐
21-50 lbs.	☐	☐	☑	☑	☐	☐
51-100 lbs.	☐	☐	☐	☑	☐	☐
100+ lbs.	☐	☐	☐	☑	☐	☐
Carrying: Negligible Amount - 10 lbs.	☐	☑	☐	☐	☐	☐
11-20 lbs.	☐	☑	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☑	☐	☐
51-100 lbs.	☐	☐	☐	☑	☐	☐
100+ lbs.	☐	☐	☐	☑	☐	☐
Pushing: (Max. Wt.: 20)	☐	☑	☐	☐	☐	☐
Pulling: (Max. Wt.: 20)	☐	☑	☐	☐	☐	☐
Climbing: Regular Stairs	☐	☐	☐	☑	☐	☐
Regular Ladders	☐	☐	☐	☑	☐	☐
Balancing:	☐	☐	☐	☑	☐	☐
Stooping:	☐	☐	☐	☑	☐	☐
Kneeling:	☐	☐	☐	☑	☐	☐
Crouching:	☐	☐	☐	☑	☐	☐
Crawling:	☐	☐	☐	☑	☐	☐
Use lower extremities for foot controls:	☐	☐	☐	☑	☐	☐
Other: _____	☐	☐	☐	☑	☐	☐
Seeing: Identify any restrictions or limitations:						
Hearing: Identify any restrictions or limitations:						

If there is any other information that may help us to better understand your patient's overall level of functional impairment (e.g. environmental conditions or the work environment), please use the below space to elaborate:

Samuel A Berkman MD

Physician Name: *(Please Print)*	Degree & Specialty:
Samuel A Berkman	MD
Address: *(Street, City, State, Zip Code)* 9001 Wilshire Blvd # 200, Beverly Hills, Ca 90211	
Telephone Number: ~~310-441-0615~~ 310-720-5572	~~Fax Number:~~ Plane / Federal Tax ID #: will give over phone
Physician Signature:	Date: 12/14/21

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

[redacted]

[redacted]

[redacted]

SAMPLE REPORT #2

Re:
Claim Number:
Date of Injury: [redacted]
MCN Number:

Dear

Thank you for allowing [redacted] to schedule an independent medical evaluation on . The following is a report of the examination performed on December [redacted]. Samuel Berkman, MD, prepared and dictated this report.

The opinions expressed in this report are those of the provider, and do not reflect the opinions of [redacted]. The examinee was informed that this examination was at the request of [redacted] that a written report would be sent to that agency, and that the examination was for evaluative purposes only. Furthermore, the examinee was informed that the purpose of the examination was to address specific injuries or conditions, as outlined by the requesting party, was not meant to constitute a general medical examination, and is not a substitute for seeking medical care from his personal provider. The examinee was also informed that during the examination he would not be required to engage in any physical maneuvers beyond what he could tolerate, or which he felt were beyond his limits, or could cause physical harm or injury.

The dictated report is as follows:

CHIEF COMPLAINTS

He is a -year-old male, out of work due to lumbar stenosis, chronic anemia and chronic prostatitis. He also has severe pain in his knees.

HISTORY OF PRESENT INJURY

He presented to the emergency room on September 10, [redacted], with acute urinary retention and difficulty voiding for a month. Exam showed a bladder diverticulum, an enlarged prostate, colon wall thickening, significant weight loss and poor intake. He was admitted. He then had a very lengthy hospitalization. Colonoscopy was done on September 11, [redacted], which showed a polypoid partially obstructing large mass found at 30 centimeters proximal to the anus. There was a polypoid lesion of 4 centimeters found at 15 centimeters proximal to the anus which was lobulated. Pathology showed inflammation and no malignancy. A general surgeon was consulted. The patient had exploratory laparotomy and a sigmoid colectomy with end colostomy and drainage of an abscess. He was discharged home on Augmentin and pain medication. He

was found to have an enlarged prostate. The urologist was consulted and he underwent a TURP on September 17, [redacted], which showed a heavily trabeculated bladder, large diverticulum at the posterior dome of the bladder and no tumor. He had significant inflammation due to catheter or obstructive prostate.

He has been followed since that time. He has had numerous visits for follow-up. Basically, what has been shown is that he has been diagnosed since with lumbar stenosis, hemorrhoids and chronic anemia. He also complains of bilateral knee pain.

CURRENT SYMPTOMS

He has been diagnosed with lumbar stenosis; however, he has never had an MRI scan of his lumbar spine.

He says he is limited in his knees and cannot go up and down stairs easily and has to go down stairs sideways. He has not had MRIs of his knees, either.

Thirdly, I do not know how severe his anemia is, but I do not think it is chronic anemia, I think it is blood loss anemia. I base this upon his descriptions of frequent bleeding from hemorrhoids. I am not supplied with any lab results from any anemia evaluation.

CHART REVIEW

I am given several records to review.

On September 16, [redacted], he had a cystoscopy, which showed no malignancies or dysplasia.

On September 17, [redacted], he had the transurethral resection, as mentioned.

September 19, [redacted], a PET scan showed a hypermetabolic infiltrate in the mid-sigmoid and diverticulosis of the colon.

September 25, [redacted], again he had a colonic mass noted.

On November 21, [redacted], he was followed up and had no complaints at that time. Diagnoses included benign neoplasm, prostatitis, diverticulitis and iron deficiency. PSA was 2.8.

On December 17, [redacted], he had cystoscopy, which showed increased median lobe and diverticulum of the bladder.

On February 6, [redacted], he had a diagnosis of lumbar stenosis made and anemia of chronic disease.

He had a specialist review in April of [redacted], which showed that he did not feel he was limited.

On April 5, [redacted], he had a hemorrhoidal exacerbation.

PAST MEDICAL HISTORY

Illnesses: Significant for hypertension, hyperlipidemia, benign prostatic hypertrophy, bladder diverticulum, erectile dysfunction, back pain and the benign neoplasm of the sigmoid colon. On April 5, [redacted], he was evaluated for his complaints. He had an exacerbation of hemorrhoids. I am not given, in the records I was given to review, any reading of a hematocrit, so I do not know how bad his anemia got from the bleeding. He says he gets bleeding in four-day increments and bright red blood. He has not required a transfusion since his second surgery when they put back the colostomy.

Operations: He has had cystoscopies, bilateral ureteral catheterizations and excision of a bladder diverticulum.

Medications: Amlodipine, Avodart, tamsulosin, Flexeril, hydrocortisone cream.

REVIEW OF SYSTEMS

Head: No headaches, seizures, syncope. Eyes: No amyloidosis, blurring. Ears: No tinnitus, hearing loss. Throat: No dysphagia. Cardiorespiratory: No chest pain, shortness of breath. GI: See HPI. GU: See HPI. Endocrine: No heat or cold intolerance. Neurologic: No numbness or tingling.

PHYSICAL EXAMINATION

He presented himself as a cheerful male, unaccompanied, drove himself to the appointment.

Well-developed, well-nourished male in no acute distress. Blood pressure . Pulse . Respirations He is afebrile. Skin: No ulcerations or nevi. Nodes: No enlargement. Discs flat. Nose clear. Throat clear. Lungs: Clear. Heart: Regular rhythm, no murmurs. Abdomen: He has a lot of induration of the abdomen near the previous surgical area. He has some swelling of his right knee. No cyanosis or clubbing. Extremities: Neurological grossly intact. Strength and sensation normal. Reflexes 2+. Down going toes.

IMPRESSION

This gentleman feels he is mainly disabled from doing his work, which is that of a Respiratory Therapist, by the pain in his knees and pain in his back. The pain in his knees is not mentioned in any medical record or any review. He says he has not wanted to bring it up to people because he was afraid, they would want to do surgery on him. He also is complaining of spinal stenosis, but has never had an MRI, so it is impossible to know what the extent is if that is the correct diagnosis. As far as anemia, there is no blood test in his record for me to review, so I do not know how severe the anemia is. It appears, though, it is due to periodic hemorrhoidal bleeding based upon his history of frequent bleeding. I was not supplied in the records with any laboratory work of the Anemia or what level it reached only that he has not required any transfusions since his second surgery.

It seems like more information is needed before a definitive opinion can be made as to whether this man's limitations prevent him from doing his work. These would include an MRI scan of both knees and an MRI of the lumbar spine. If they show severe disease, then it would appear that he may not be able to do the work of an Inhalation Therapist, which involves 12 hours straight of work, lifting heavy packages up to 50 pounds, standing for prolonged periods of time by the bedside of the patient doing tests and attending to the patients' breathing issues. He needs these tests done in order to determine whether he is able to do this work. Otherwise, what I can say is that his history of having to go down stairs sideways is very indicative of a severe problem in his knees. However, he could just have a torn meniscus for all we know.

DISCUSSION

The following is in response to the questions in your cover letter.

1. *Please refrain from using the word "patient" in reference to the individual under examination. Please refer to this individual as "claimant' in your report/dictation.* Noted.

2. *Please add the following statement to your report: "I've reviewed all the medical information that was provided to [redacted] on behalf of the customer."*

   I have reviewed all the medical information provided to [redacted] on behalf of the customer.

3. *Based on your examination and review of the provided records of physically functionally impaired? Describe in full and enumerate the specific observations, examination findings, diagnostic tests and functional assessments demonstrating the impairment and its extent.*

   It seems like more information is needed before a definitive opinion can be made as to whether this man's limitations prevent him from doing his work. These would include an MRI scan of both knees and an MRI of the lumbar spine. If they show severe disease, then it would appear that he may not be able to do the work of an Inhalation Therapist, which involves 12 hours straight of work, lifting heavy packages up to 50 pounds, standing for prolonged periods of time by the bedside of the patient doing tests and attending to the patients' breathing issues. He needs these tests done in order to determine whether he is able to do this work. Otherwise, what I can say is that his history of having to go down stairs sideways is very indicative of a severe problem in his knees. However, he could just have a torn meniscus for all we know.

4. *Are work activity restrictions medically necessary; enumerate these and indicate if they are based on your professional experience, the consensus opinion of a professional body (identify), and/or scientific literature (provide citations).*

   Yes, he has severe pain in knees and back. See details above.

5. *Complete the enclosed Physical Abilities Assessment Form. Provide clinical detail in your narrative report to support any restrictions that you note on this form. Note that it is critical that the narrative portion of your report that addresses work capabilities precisely match the*

Physical Abilities Assessment Form. Please be sure to explain your rationale for any restrictions given.

See completed PAA form.

6. *Describe how presented themselves at the evaluation (specify if they drove themselves and comment on their general appearance, mood, and level of cooperation).*

He presented himself as a cheerful male, unaccompanied, drove himself to the appointment.

All conclusions in this report are solely the opinions of the author. There is no conflict of interest.

[redacted] *selection/retention of the author for this consultation and the compensation paid to the author is not based on support or nonsupport of impairment.*

There is no doctor/provider-patient treatment relationship.

All conclusions are advisory only, independently developed by the author, and based upon the best professional judgment of the examiner considering all the data available at the time of preparation of this report.

All opinions and conclusions are based on a reasonable degree of professional judgment, as absolute predictions are not possible.

[redacted] *does not make claim decisions and is not informed of any claim decisions.*

Samuel Berkman, MD
Internal Medicine, Board Certified
License Number: G00023110

Physical Ability Assessment

Life Insurance Company of North America
Connecticut General Life Insurance Company
Cigna Life Insurance Company of New York
Great-West Healthcare Administered by Cigna

Cigna.

We are evaluating a disability claim for our customer and need to determine functional impairment. Please check the boxes corresponding to his/her level of physical functioning. **Please submit any and all medical documentation, including documented observations, physical exam findings and functional assessments. We appreciate your prompt response to this request.**

[redacted]

Customer Name _____ Date of birth _____

ICD codes(s): Spinal stenosis M48.00

Your assessment of our customer's physical abilities is based on *(check all that apply)*:

- ☐ Customer's report
- ☑ Observation
- ☑ Examination
- ☐ Your functional assessment
- ☐ A formal functional capacity evaluation (FCE)
- ☐ A diagnosis that implies an increased risk of harm requiring physician imposed work activity restrictions

_____

_____

_____

Throughout an 8-hour workday, to the extent that positional changes are necessary, with rest breaks and meal breaks at appropriate intervals, he or she can tolerate the following activities for the specified durations:

		Constantly: > 5.5 Hrs/Day > 2/3 of the Day	Frequently: 2.5 - 5.5 Hrs/Day 1/3 - 2/3 of the Day	Occasionally: Up to 2.5 Hrs/Day Up to 1/3 of the Day	0 Hours	Check if supported by clinical findings	Does Not Apply to Diagnosis
Sitting:		☑	☐	☐	☐	☐	☐
Standing:		☐	☐	☑	☐	☐	☐
Walking:		☐	☐	☑	☐	☐	☐
Reaching:	Overhead	☑	☐	☐	☐	☐	☐
	Desk Level	☑	☐	☐	☐	☐	☐
	Below Waist	☑	☐	☐	☐	☐	☐
Fine Manipulation:	Right:	☑	☐	☐	☐	☐	☐
	Left:	☑	☐	☐	☐	☐	☐
Simple Grasp:	Right:	☑	☐	☐	☐	☐	☐
	Left:	☑	☐	☐	☐	☐	☐
Firm Grasp:	Right:	☑	☐	☐	☐	☐	☐
	Left:	☑	☐	☐	☐	☐	☐

	Constantly: > 5.5 Hrs/Day > 2/3 of the Day	Frequently: 2.5 - 5.5 Hrs/Day 1/3 - 2/3 of the Day	Occasionally: Up to 2.5 Hrs/Day Up to 1/3 of the Day	0 Hours	Check if supported by clinical findings	Does Not Apply to Diagnosis
Lifting: Negligible Amount - 10 lbs.	☑	☐	☐	☐	☐	☐
11-20 lbs.	☐	☐	☑	☐	☐	☐
21-50 lbs.	☐	☐	☑	☐	☐	☐
51-100 lbs.	☐	☐	☐	☒	☐	☐
100+ lbs.	☐	☐	☐	☒	☐	☐
Carrying: Negligible Amount - 10 lbs.	☑	☐	☑	☐	☐	☐
11-20 lbs.	☐	☐	☑	☐	☐	☐
21-50 lbs.	☐	☐	☐	☑	☐	☐
51-100 lbs.	☐	☐	☐	☒	☐	☐
100+ lbs.	☐	☐	☐	☑	☐	☐
Pushing: (Max. Wt.: 20)	☑	☐	☐	☐	☐	☐
Pulling: (Max. Wt.: 20)	☑	☐	☐	☐	☐	☐
Climbing: Regular Stairs	☐	☐	☐	☒	☐	☐
Regular Ladders	☐	☐	☐	☒	☐	☐
Balancing:	☐	☐	☐	☒	☐	☐
Stooping:	☐	☐	☐	☒	☐	☐
Kneeling:	☐	☐	☐	☒	☐	☐
Crouching:	☐	☐	☐	☒	☐	☐
Crawling:	☐	☐	☐	☒	☐	☐
Use lower extremities for foot controls:	☐	☐	☒	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐
Seeing: Identify any restrictions or limitations:	he has severe pain in knee + back					
Hearing: Identify any restrictions or limitations:	climbing, bending					

If there is any other information that may help us to better understand your patient's overall level of functional impairment (e.g. environmental conditions or the work environment), please use the below space to elaborate:

Physician Name: *(Please Print)* Samuel A Berkan	Degree & Specialty: MD
Address: *(Street, City, State, Zip Code)* 9601 Wilshire Blvd, #200 Beverly Hills, Ca 90210	
Telephone Number: 310-726-5572 / Fax Number:	Federal Tax ID #: will give at exam place
Physician Signature:	Date: 12/14/21

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

June 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

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

FOR: July 6, 2022, Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
STEVEN N. BROURMAN, M.D. - ORTHOPEDICS

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 Steven N. Brourman, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

The Disability Retirement Services Division engaged I.M.S Board Certified Physicians to discuss potential candidates for the LACERA Panel of Examining Physicians. I.M.S. manages a panel of board-certified physicians specializing in Medical-Legal and Workers' Compensation Evaluations. The I.M.S network includes expertly trained and highly skilled physicians within a variety of specialties. With locations throughout Central and Southern California.

Steven N. Brourman, M.D. is Board Certified in Orthopedic Surgery with an subspeciality in Hand Surgery. He received his medical degree from University of California in 1981 and completed general residency at Harvard Surgical Center at Harvard University, orthopedic surgery residency at The Hospital for Special Surgery at Cornel University Medical Center and fellowships at Allegheny General Hospital and L' Institute Francais de la Main in Paris. Dr. Brourman has over 25 years' 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. Staff will also provide an overview of the Quality Control Questionnaire process and procedures.

On June 8, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Steven N. Brourman, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Steven N. Brourman, 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 2/1/2022
Physician Name: STEVEN N. BROURMAN, MD	Group Name: STEVEN N. BROURMAN, MD
Primary Address: 14600 SHERMAN WAY # 100 A VAN NUYS, CA 91405	
Primary Contact: CLAUDIA MARTINEZ	Title: OFFICE MANAGER
Telephone: 818-815-3900 Fax: 424-269-7009	Email: [redacted]
Secondary Address: 3340 W. BALL ROAD UNIT E ANAHEIM, CA 92804	
Telephone: 714-565-1000 Fax: 714-648-0089	Email: [redacted]

PHYSICIAN BACKGROUND	
Field of Specialty: ORTHOPEDIC SURGERY Board Certification ☒Yes ☐No	Subspecialty: HAND SURGERY Board Certification ☒Yes ☐ No
License # G48327 Expiration Date: 03-31-2022	
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	25	Treatment	40
IME	25	Evaluations	60
QME	25	Research	
Workers' Compensation Evaluations	25	Teaching	
Disability Evaluations			100 %

Med-Legal Reports	25		

Performing Medical Evaluations for Public Organizations ☒Yes ☐No

Performing Medical Evaluations for Private Organizations ☒Yes ☐No

Please Names of Organizations: WORKERS COMPENSATION APPLICANT, DEFENSE ATTORNEYS AND INSURANCE COMPANIES

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).
48 HOURS PRIOR TO EXAMINATION DATE

Cancelled Exams that do not adhere to your stated policy:	Fee: $ **500.00**
Cancelled Hearings that do not adhere to your stated policy:	Fee: $ **Click or tap here to enter text.**

Name of person completing this form:

Print Name: Claudia Martinez	Title: Office manager
Physician Signature:	Date 2/01/2022

You may attach additional pages if necessary.

Revised: 12/8/21

Steven N. Brourman M.D.

Diplomate American Board of Orthopedic Surgery
Fellow American Academy of Orthopedic Surgeons
Certificate of Added Qualifications in Surgery of the Hand
American Society for Surgery of the Hand

CURRICULUM VITAE

Primary Address: Steven N. Brourman, MD
10700 Santa Monica Blvd. # 309 Los Angeles, CA 90025
Telephone: (310) 657-2202

Other Location: Seventeenth Street Orthopedic
3340 W. Ball Road Suite E Anaheim, CA 92804
Telephone: (714) 565-5000

Licensure: California Board of Medical Examiners G48327

Education:

College:	Stanford University Palo Alto, California Bachelor of Science, Biology	1977
Medical School:	University of California at Los Angeles Doctor of Medicine	1981

Medical Training:

Internship:

University of Southern California Los Angeles County Medical Center General Surgery	1981 to 1982

Residency General:

General Surgery Deaconess – Harvard Surgical Center Harvard University Boston, Massachusetts	1982 to 1983

Orthopedic Surgery:

	Orthopedic Surgery The Hospital for Special Surgery The New York Hospital Cornell University Medical Center	1983 to 1986
Fellowships:	Hand Surgery Fellowship Allegheny General Hospital Pittsburgh, Pennsylvania	1986 to 1987
	Hand Surgery Fellowship L' Institut Francais de la Main Paris, France	1987
	Private practice, Orthopedics and Hand Surgery Specialty, Beverly Hills, Los Angeles, Orange County	1987-present

Academic Background Research

Publications: Available upon request.

Formal Presentations:

" Flexor Tendon Injuries of the Hand " Allegheny General Hospital Pittsburgh, Pennsylvania	1987
" Thumb Basal Joint Arthritis " Allegheny General Hospital – Hand Surgery Service Pittsburgh, Pennsylvania	1987
" Rheumatoid Arthritis of the Hand " Plastic Surgery, Orthopedic Surgery & Hand Surgery Conference University of Pittsburg School of Medicine Pittsburgh, Pennsylvania	1987
" Orthopedic Surgery in Rheumatoid Arthritis " Rheumatology Conference Cedars-Sinai Medical Center Los Angeles, California	1987
" Radial Shortening for Keinbock's Disease " Annual Meeting of the American Society for Surgery of the Hand Baltimore, Maryland	1988
*" Rheumatoid Hand, Wrist * elbow Surgery: Grand Rounds "* U.C. Irvine Orthopedic Surgery Residence	1990

Director of Weekly Hand Surgery Teaching Conference 1989 to 1994
Long Beach VA Hospital

Instructor: Endoscopic Carpal tunnel Surgery
Agee Carpal Tunnel Release System
(Taught several workshops to orthopedic surgeons)

Certifications:

Diplomate, American Board of Orthopedic Surgery 1990
Certificate, Added Qualifications for Surgery of the Hand 1992
Fellow, American Academy of Orthopedic Surgeons 1993
American Society for Surgery of the Hand AME, AME, IME 1996
Re-certification (American Board Orthopedic Surgery) 2000
RE-certification (Surgery of the Hand) 2002

Hospital Affiliations:

Cedars Sinai Medical Center
Olympia Medical Center

Academic Appointment:

University of California at Irvine 1989 to 1994
Assistant clinical professor, Orthopedics
Irvine, California

Veterans' Hospital of Long Beach 1989 to 1994
Instructor, Hand Surgery & Upper Extremity reconstructive surgery
Chief hand and upper extremity service

Professional Societies:

Local Organizations:

Los Angeles County Medical Association
California Medical Association

National Organizations:

American Medical Association
American College of Sports Medicine
Fellow, American Academy of Orthopedic Surgeons
Phi Delta Epsilon
American Society for Surgery of the Hand

Steven N. Brourman, M.D.

Diplomate of American Board of Orthopedic Surgery
Certificate for Added Qualifications for Surgery of the Hand
Fellow American Academy of Orthopedic Surgeons
American Society for Surgery of the Hand
Qualified Medical Evaluator
10700 Santa Monica Blvd., Suite 309 Los Angeles, California 90025

DATE

[redacted]

PATIENT:
EMPLOYER: City of [redacted]
JOB DESCRIPTION: [redacted] Operator
SOCIAL SECURITY #:
WCAB#:
CLAIM #:
D/INJURY:
D/EXAMINATION:

AGREED MEDICAL EXAMINATION

Dear Ladies and Gentlemen,

Pursuant to your request, I performed an Orthopedic Examination on Mr. _____ __year-old, right/left- hand dominant male, regarding his industrial injury. This evaluation was taken at my office located at 10700 Santa Monica Blvd., Suite 309, Los Angeles, California 90025. The following is a summary of my findings from an office visit on _____ (date).

He is currently taking Tylenol as needed.

This report represents a comprehensive Agreed Medical-Legal Evaluation. The charges are derived according to section 9795 of the labor code for medical-legal fees and includes the following number of pages for the medical records reviewed: 0 pages

Mailing Address:
14600 Sherman Way, Suite101A • Van Nuys, California 91405
TEL: (818) 815-3900 FAX: (818) 933-7550

Please be advised this is a medical-legal evaluation and this does not qualify for a PPO/ Network Discount.

PAST EMPLOYMENT:

He has worked for the subject employer for about 15 years.

JOB DESCRIPTION:

In approximately [redacted], he began working for City of [redacted] as a [redacted] operator.

His job responsibilities entailed operating a company truck and picking up dead wildlife and animals from [redacted] area. He normally worked alone. He notes that he had to move the animals manually. If they are heavy, he would use a crane to pick up heavy animals.

The physical requirements consisted of sitting when driving; frequent getting on and off his truck; prolonged standing and walking; repetitive bending, stooping and squatting; repetitive twisting, turning and reaching above and below shoulder level and waist level; repetitive arm and hand movement, simple and forceful grasping, torquing motions and fine finger manipulation. He lifted and carried up to 65 pounds. He worked 8 hours per day, 5 days per week.

CONCURRENT EMPLOYMENT:

The applicant denies working for a concurrent employer or earning cash on the side for additional income.

SUBSEQUENT EMPLOYMENT:

He denies subsequent employment.

PERIODS OF TEMPORARY TOTAL DISABILITY:

He has not worked since July 24, [redacted],

CURRENT WORK STATUS:

The applicant last worked for the above employer on July 24, [redacted] when he was taken off work by Dr. [redacted].

He is not working. He has been receiving workers' compensation benefits provided by the carrier.

HISTORY OF INJURY & TREATMENT:

Mr. [redacted] reports on July 24, [redacted], he was parked on the street and eating his lunch when suddenly [redacted] tow truck drove around the curb really fast while towing a vehicle. He states that the vehicle he was towing went into a jack knife and flew into his truck and hit him on the driver's side of his truck. He saw it coming and he tried to react and turn to get out of the way. Upon impact, he was forcefully jolted as he did not have a seat belt as he was eating and not driving. His right wrist hit the back of the truck. His right knee hit the steering column. He managed to exit the truck. He gradually began to experience pain in the neck, low back, right elbow, forearm to the right wrist and right knee. He states that his right wrist was cut and bleeding. Police arrived on the scene and a police report was completed. He managed to drive away from the scene.

That evening, he had increased pain in the low back and gradually into the upper and mid back.

On the following day, he presented to work and a report was completed. He was referred to Dr. [redacted]

He was examined by Dr. [redacted] and x-rays were obtained and he was told there were no fractures. Medication was prescribed. He was referred for physical therapy. He was taken off work.

He received physical therapy for his right elbow, right wrist, neck, back and right knee for a while, which provided relief from the pain.

He underwent MRIs of the neck, back, right elbow, and right wrist, but was not provided with the results.

He remains under the care of Dr. [redacted] and was last seen in early May [redacted]. He has a follow-up appointment in June [redacted].

He has been attending acupuncture treatment twice per week for his back, which provides relief from the pain.

He states that he feels anxious to get back to work.

He is currently taking Tylenol as needed.

CURRENT ORTHOPEDIC COMPLAINTS:

CERVICAL SPINE: The applicant experiences pain in the neck, which is present on and off. The pain is aggravated with prolonged positioning of the head and neck.

RIGHT ELBOW/FOREARM: He experiences pain in his right elbow and forearm, which comes and goes. The pain increases occasionally with repetitive arm movement.

RIGHT HAND/WRIST: He experiences slight pain in his right wrist, which comes and goes as it has gotten better.

LEFT ELBOW/HAND: He denies injury to his left elbow and wrist and hand.

THORACIC SPINE: He experiences tension pain in his upper and mid back, which comes and goes. The pain increases with prolonged positioning of his back.

LUMBAR SPINE: He experiences pain in his low back which is present on and off. There is radiating pain from his low back into his buttock, which comes and goes. The pain increases with prolonged sitting and ascending and descending stairs. He has difficulty falling asleep and awakens during the night due to his low back pain. There is currently no spasm in his low back.

RIGHT KNEE: He notes that his right knee pain resolved.

ACTIVITIES OF DAILY LIVING:

He has problems with prolonged bending to tie his shoes.

He denies problems doing household activities.

He has problems getting into a low vehicle.

PAST MEDICAL HISTORY:

PREVIOUS WORKERS' COMPENSATION CLAIMS:

Years ago, he injured his back, received medical care and physical therapy. He did not litigate the claim and recovered.

PRIOR NON-INDUSTRIAL INJURIES:

He denies having prior sports/personal injuries.

PRIOR BICYCLE/MOTOR VEHICLE ACCIDENTS:

He denies being involved in bicycle/motor vehicle accidents.

SUBSEQUENT NON-INDUSTRIAL INJURIES:

He denies having subsequent injuries.

PREVIOUS SURGERIES:

He has not had surgery.

HOSPITALIZATION:

He has not been hospitalized.

SOCIAL HISTORY:

He was born in [redacted] on March 12, [redacted]. He has a domestic partner and has six adult children in good health. He lives with his domestic partner, Diane.

ALCOHOL:

He does not drink alcohol.

SMOKE:

He does not smoke.

ILLICIT DRUGS:

He does not use illicit drugs.

FAMILY HISTORY:

His father died of unknown causes. His mother died of natural causes. He has two brothers and two sisters, one brother was shot and killed. His other siblings are in good health.

PERSONAL HISTORY:

He completed 12th grade. Afterward, he attended some college.

He did not serve in the military.

He drives an automatic vehicle.

HOBBIES/SPORTS/OTHER INTEREST:

Previously, he did not participate in sports.

CURRENT MEDICATION/VITAMIN SUPPLEMENTS/MEDICATED LOTION:

He is currently taking Tylenol as needed.

REVIEW OF SYSTEMS

CONSTITUTIONAL:

The applicant specifically denied recent weight loss or gain, fever, chills, fatigue, weakness or other constitutional problems.

EYES:

The applicant specifically denied pain, redness, glaucoma or other eye problems.

He wears reading glasses.

EARS/NOSE/THROAT/MOUTH:

The applicant specifically denied ear infections, hearing loss, vertigo, sensitivity to noise, sinus pain, sore throat, gum disease, difficulty swallowing, hoarseness or other ears/nose/throat/mouth problems.

CARDIOVASCULAR:

The applicant specifically denied chest pain, high blood pressure, thrombophlebitis, palpitation, dizziness or other cardiovascular problems.

RESPIRATORY:

The applicant specifically denied shortness of breath, asthma, wheezing, chronic cough, bronchitis or other respiratory problems.

GASTROINTESTINAL:

The applicant specifically denied nausea, diarrhea, constipation, flatus, changes in bowel habits, indigestion or other gastrointestinal problems.

GENITOURINARY:

The applicant specifically denied frequent urination, blood in urine, painful urination, changes in urination stream, urinary retention, or other genitourinary problems.

INTEGUMENTARY:

The applicant specifically denied skin lesions, mole changes, nail changes, hair loss, change in breast or other integumentary problems.

MUSCULOSKELETAL:

The applicant specifically denied symptoms of gout, arthritis or other musculoskeletal problems.

NEUROLOGICAL:

The applicant specifically denied symptoms of seizures, memory loss, tremors, blackouts, paralysis, stroke, headaches or other neurological problems.

PSYCHIATRIC:

The applicant specifically denied depression, anxiety, stress, mood swings, panic attacks or other psychiatric problems.

ENDOCRINE:

The applicant specifically denied diabetes, high cholesterol, thyroid problems, heat or cold intolerance, increased thirst, goiter, feeling tired or sluggish or other endocrine problems.

HEMATOLOGICAL/LYMPHATIC:

The applicant specifically denied anemia, easy bruising, swollen lymph nodes, past transfusion or other hematological/lymphatic problems.

ALLERGIC/IMMUNOLOGIC:

The applicant specifically denies allergic reactions, hay fever, frequent infection, HIV-positive, hepatitis or other allergic/immunology problems.

ONCOLOGY/MALIGNANCIES:

The applicant specifically denies a history of cancer.

PHYSICAL EXAMINATION:

GENERAL:
HEIGHT: [redacted] feet [redacted] inches
WEIGHT: [redacted] Pounds

The applicant is **right** hand dominant.

CERVICAL SPINE EXAMINATION:

Inspection:

There is no loss of the normal cervical lordosis, nor are there any other abnormal curvatures.
There is no visible deformity or step-off.
There is no muscle guarding or spasm present.

Range of motion of the cervical spine:

	1	2	3	Normal
Occipital Flex:	18°	18°	18°	Occ-T1=50°
T-1 Flexion:	8°	8°	8°	
Occipital Ext:	25°	25°	25°	Occ-T1=60°
T-1 Extension:	15°	15°	15°	
Occipital Right:	30°	30°	30°	Occ-T1=45°
R-Lateral Bend (T1):	15°	15°	15°	
Occipital Left:	15°	15°	15°	Occ-T1=45°
L-Lateral Bend (T1):	10°	10°	8°	

Right Occ Rotation:	50°	50°	50°	80°
Left Occ Rotation:	30°	30°	30°	80°

The applicant did not complain of increasing pain towards terminal range of motion.

Palpation:

There is no tenderness to palpation of the paraspinal musculature.
There are no palpable abnormalities.

Provocative Testing:

	RIGHT	LEFT
Spurling Test:	Negative	Negative
Adson's Test:	Negative	Negative

BILATERAL SHOULDER EXAMINATION:

Inspection:

There is no evidence of atrophy, hypertrophy or asymmetry bilaterally.
There is no erythema, cyanosis, or other color changes bilaterally.
There is no visible subluxation of the glenohumeral joints bilaterally.
There is no deformity of the clavicle or acromioclavicular joints bilaterally.

Range of motion of the shoulders:

	RIGHT	LEFT	NORMAL
Flexion:	180°	180°	180°
Abduction:	170°	170°	170°
External Rotation:	80°	80°	80°
Internal Rotation:	80°	80°	80°

The patient did not complain of increasing pain towards terminal range of motion.

There was not a painful arc against resisted abduction bilaterally.

Palpation:

There is no myofascial tenderness to palpation bilaterally of the trapezius or posterior shoulder girdle.
There is no acromioclavicular joint tenderness to palpation bilaterally

There is no biceps tendon tenderness to palpation bilaterally.
There is no supraspinatus tendon tenderness to palpation bilaterally.

Provocative Testing:

	RIGHT	LEFT
Apprehension Test:	Negative	Negative
Posterior Apprehension Test:	Negative	Negative
Supraspinatus Test:	Negative	Negative
Yergason's Test:	Negative	Negative
Drop Arm Test:	Negative	Negative
Neer's Impingement Test:	Negative	Negative
Hawkins-Kennedy Impingement:	Negative	Negative
Roo's Test:	Negative	Negative

<u>BILATERAL ELBOW EXAMINATION</u>:

Inspection:

There is no visible deformity or asymmetry bilaterally.
There is no bursa edema, erythema, or warmth.

Range of motion of the elbow, as measured with inclinometer, is as follows:

	Right	Left	Normal
Flexion:	140°	140°	140°
Extension:	0°	0°	0°-10° hyperextension
Supination:	70°	70°	70°
Pronation:	80°	80°	80°

Palpation:

There is no tenderness to palpation of the joint articulations bilaterally.
There is no tenderness to palpation of the extensor attachment at the lateral epicondyle bilaterally.
There is no tenderness to palpation of the flexor attachment at the medial epicondyle bilaterally.
There is no tenderness to palpation of the olecranon bursa bilaterally.

Provocative Testing:

	RIGHT	LEFT
Tennis Elbow Tests:	Negative	Negative
Golfer's Elbow Test:	Negative	Negative
Tinel's @ Elbow:	Negative	Negative
Pronator Teres Test:	Negative	Negative
Elbow Flexion Test:	Negative	Negative

BILATERAL HAND AND WRIST EXAMINATION:

Inspection:

There are no visible deformities, masses, or asymmetry
There are no visible nodules or contractures
There is no intrinsic musculature atrophy

Range of motion of the wrists:

	RIGHT	LEFT	NORMAL
Extension:	50°	60°	60°
Flexion:	50°	60°	60°
Radial Deviation:	15°	20°	20°
Ulnar Deviation:	20°	30°	30°

He can make a complete fist with both hands.

Palpation:

There is no tenderness over the:
Scaphoid or lunate carpal bones
Wrist flexion/extension crease
Tendons of the abductor pollicis longus/extensor pollicis brevis in the first dorsal compartment
Carpometacarpal joints of the hand
Triangular fibrocartilage complex/ulnocarpal ligament /distal radioulnar joint

There is no popping or triggering of the finger flexor tendons

Provocative Testing:

	RIGHT	LEFT
Tinel's:	Negative	Negative
Phalen's:	Negative	Negative
Semmes-Weinstein:	Negative	Negative
Flick's	Negative	Negative
Finkelstein's	Negative	Negative
Durkan's median compression test:	Negative	Negative

Grip strength with Jamar Dynamometer:

RIGHT (dominant)	LEFT
32 kg	30 kg
28 kg	29 kg
24 kg	28 kg

Measurements of upper extremities:

	RIGHT	LEFT
Arm: (4" above elbow)	44 cm	45 ½ cm
Forearm: (4" below elbow)	36 cm	36 cm
Wrist:	19 cm	19 cm

<u>THORACIC SPINE EXAMINATION</u>:

Inspection:

There is no excessive kyphosis past the normal thoracic curvature.
There is no visible scoliosis.
There are no visible deformities or step-off.
Chest expansion is normal.
There is no muscle guarding/spasm present.

<u>Range of motion of the thoracic spine</u>:

	1	2	3	Normal
T-1 Flexion:	50°	50°	50°	T1-T12=60°
T-12 Flex:	28°	25°	25°	
T-1 R-Rotation:	20°	20°	20°	T1-T12=30°
T-12 R-Rotation:	10°	10°	10°	
T-1 L-Rotation:	30°	30°	30°	T1-T12=30°
T-12 L-Rotation:	15°	15°	15°	

The applicant did not complain of increasing pain towards terminal range of motion

Palpation:

There is no paraspinal musculature tenderness to palpation.
There are no palpable abnormalities.

GAIT:

The gait is not antalgic.
The applicant is able to walk on heels and toes.
The applicant ambulates without assistance of crutches/cane.

LUMBAR SPINE EXAMINATION:

Inspection:

There is no loss of the normal lumbar lordosis, nor are there any other abnormal curvatures.
There is no visible deformity, or step-off.
There is no muscle guarding/spasm present.

Range of motion of the lumbar spine:

	1	2	3	NORMAL
T-12 Flexion:	30°	30°	30°	T12-Sac=60°
Sac-Flex:	15°	15°	15°	
T-12 Ext:	20°	20°	20°	T12-Sac=25°
Sac Ext:	10°	10°	10°	
T-12 Right:	35°	35°	35°	T12-Sac=25°
Sac-Right:	15°	15°	15°	
T-12 Left:	30°	30°	30°	T12-Sac=25°
Sac-Left:	13°	13°	13°	

Straight leg raise is negative bilaterally.

The applicant did not complain of increasing pain towards terminal range of motion

Palpation:

There is no paraspinal musculature tenderness to palpation.

There is no tenderness to palpation of the spinous processes.
There is no tenderness to palpation of the bilateral sacroiliac joints.
There is no tenderness to palpation of the piriformis/gluteus groups bilaterally.
There are no palpable abnormalities.

Provocative Testing:

	RIGHT	LEFT
Piriformis Test:	Negative	Negative
FABERE Test:	Negative	Negative

BILATERAL HIP EXAMINATION:

Inspection:

There are no visible deformities or asymmetries.

Range of motion of the hips:

	RIGHT	LEFT	NORMAL
Flexion:	100°	100°	100°
Extension:	30°	30°	30°
Internal Rotation:	40°	40°	40°
External Rotation:	50°	50°	50°
Abduction:	40°	40°	40°
Adduction:	20°	20°	20°

There was no pain throughout the range of motion testing bilaterally.

Palpation:

There is no tenderness or swelling present at the hip joint bilaterally.
There is no greater trochanter tenderness to palpation bilaterally.

Provocative Testing:

	RIGHT	LEFT
Patrick's/Fabere:	Negative	Negative
Trendelenburg's Sign:	Negative	Negative

WADDELL'S SIGNS OF NON-ORGANIC SPINAL PAIN:
(Three out of 5 is significant for spinal pain of non-organic origin)

1. Tenderness	Present ( )	Absent (x)
2. Simulation:	Present ( )	Absent (x)
a. Axial loading		
b. Rotation		
3. Distraction	Present ( )	Absent (x)
4. Regional Disturbance:	Present ( )	Absent (x)
5. Overreaction:	Present ( )	Absent (x)
a. Weakness		
b. Sensory loss		

BILATERAL KNEE EXAMINATION:

Inspection:

There was no visible erythema or effusion present bilaterally.
Q angle was normal bilaterally.
Patellar tracking appears normal bilaterally.

Range of motion of the knees:

	RIGHT	LEFT	NORMAL
Flexion:	130°	130°	130°
Extension:	0°	0°	0°

There is no popping, crepitus, or locking during range of motion testing bilaterally.

There is no pain during range of motion testing bilaterally.

Palpation:

There are no palpable masses bilaterally.
There is no tenderness to palpation of any knee structures bilaterally.
There is no joint line tenderness bilaterally.
There is no warmth of the knees bilaterally.

Provocative Testing:

	RIGHT	LEFT
Lachman's/Anterior Drawer Sign:	Negative	Negative
Posterior Sag/Drawer Sign	Negative	Negative
Valgus/Varus Stress	Negative	Negative
Rotatory Instability Testing:	Negative	Negative
Pivot-Shift Test:	Negative	Negative
McMurray's:	Negative	Negative
Apley's Test:	Negative	Negative

BILATERAL ANKLE AND FOOT EXAMINATION:

Inspection:

There is no edema or erythema present bilaterally.
There is no visible deformity/step-off bilaterally.
There is no pes planus or pes cavus present bilaterally.
There is no intrinsic atrophy noted.

Range of motion of the ankles:

	RIGHT	LEFT	NORMAL
Flexion:	40°	40°	40°
Extension:	20°	20°	20°
Inversion:	30°	30°	30°
Eversion:	20°	20°	20°

There was no pain throughout the range of motion testing bilaterally.

Palpation:

There is no tenderness to palpation bilaterally.
There are no palpable masses or deformities bilaterally.
There is no tenderness to palpation of the joints bilaterally.
Peripheral pulses are normal bilaterally.

Provocative Testing:

	RIGHT	LEFT
Anterior Drawer Sign:	Negative	Negative
Talar Tilt Test:	Negative	Negative
Thompson Test:	Negative	Negative
Morton's Test:	Negative	Negative

Lower Extremity Circumferences:

	RIGHT	LEFT
Thigh: (4" above patella)	62 cm	62 cm
Calf: (4" below patella)	42 cm	43 cm

NEUROLOGICAL EXAMINATION:

Mental Status: Alert & oriented x 3, no deficits in general fund of information or concentration

CN 2-12: Grossly Intact

Rapid Alternating: No slowness or gross deficits in coordination bilaterally

Motor Exam:

	RIGHT	LEFT
Biceps:	5/5	5/5
Triceps:	5/5	5/5

Shoulder:	RIGHT	LEFT
Abduction:	5/5	5/5
Forward Flexion:	5/5	5/5
Extension:	5/5	5/5
Internal Rotation:	5/5	5/5
External Rotation:	5/5	5/5
Deltoid:	5/5	5/5
Wrist Extension:	5/5	5/5
Finger Abduction:	5/5	5/5
Hip Flexion:	5/5	5/5

Knee Extension:	5/5	5/5
Knee Flexion:	5/5	5/5
Plantar Flexion:	5/5	5/5
Dorsiflexion:	5/5	5/5

Deep Tendon Reflexes:

Triceps:	Brisk with no asymmetry
Biceps:	Brisk with no asymmetry
Patellar:	Brisk with no asymmetry
Ankle:	Brisk with no asymmetry

Sensory Exam:

Pinprick	Intact with no dermatomal deficits bilaterally
Light Touch	Intact with no dermatomal deficits bilaterally
Proprioception	Intact bilaterally

RADIOGRAPHIC STUDIES:

The following x-rays were obtained today in my office.

CERVICAL SPINE (2-3 views) – There are no soft tissues, vertebral body or disc space abnormalities present. The intervertebral foramina show no encroachment. There is no evidence of fracture or dislocation.

RIGHT HAND AND WRIST (2 views each) – The bony structures are of normal density. There is no fracture, dislocation or subluxation present. There is no soft tissue abnormality demonstrated.

LEFT HAND AND WRIST (2 views each) – The bony structures are of normal density. There is no fracture, dislocation or subluxation present. There is no soft tissue abnormality demonstrated.

LUMBOSACRAL SPINE (2-3 views) – There are no soft tissues, vertebral body or disc space abnormalities present. The intervertebral foramina show no encroachment. There is no evidence of fracture or dislocation.

PELVIS - No fracture, dislocation, or subluxation is seen. No radiopaque foreign bodies or effusions are demonstrated.

REVIEW OF MEDICAL RECORDS:

Medical records were not available for review at this time. Should medical records become available, please forward them to my office for my review.

DIAGNOSES:

1. Cervical spine strain, rule out cervical radiculopathy.
2. Lumbar spine strain, rule out lumbar radiculopathy.
3. Rule out internal derangement, right wrist.

DISCUSSION:

Mr. _____ presents for orthopedic evaluation of injuries sustained during the course and scope of his usual and customary job duties with City of [redacted] as a [redacted] operator. I examined the patient in the capacity as an Agreed Medical Evaluator.

To address the nature and extent of his complaints I need to review updated MRI scans of the neck, back and right wrist, however he stated that he had these studies performed recently and I would rather not repeat these studies. It would be best if I could review the recent studies obtained and these are therefore requested for review. He has also had electrodiagnostic studies and I would rather not repeat these studies. I would like to request that the electrodiagnostic studies be sent to me for review along with his complete set of medical records.

He has been on disability since the date of injury but plans to return to work on June 16, [redacted]. He noted that his treatment was delayed because of the pandemic.

In order to determine the nature and extent of the patient's claimed injuries and disability, I need to review updated diagnostic testing. He will be sent for ultrasound studies of the right hand and wrist.

The diagnostic studies will provide substantial medical evidence to help determine if there are any abnormal objective findings of the body parts in question. Electrodiagnostic studies are the gold standard to diagnoses and determine the severity of neuropathic processes and nerve entrapments, such as carpal tunnel syndrome. (For example, a nerve study will determine if sensory or motor loss is mild, moderate or severe, and this information can then be used to provide the most accurate rating impairment in the AMA Guides, 5th Edition). MRI scans, ultrasounds and CT scans provide important information with a high level of specific anatomical detail about articular and soft tissue lesions. These objective tests then can be compared to the

patient's subjective complaints and physical examination findings in order to formulate the highest quality opinion regarding impairment of the claimed injured body parts.

In order to be compliant with Labor Code 139.2, requiring a report be submitted within 30 days of examination, I have prepared an initial report.

Today's evaluation is considered preliminary.

Mr. [redacted] is scheduled to return in four weeks with the results of his work-up and medical records reviewed. At that time, I will issue a complete report to address the questions raised in the _____(date) cover letter prepared by _____.

Per California Code of Regulations § 9794 (a) (1), subjective complaints and physical findings during the evaluation warranted diagnostic testing in order to complete the evaluation. The medical records provided did not include adequate medical information.

Please note that the Division of Workers' Compensation has clearly stated that civil penalties will be assessed under State Labor Code Sections 129 and 129.5 if this bill is not paid within the time frame specified by the Labor Code. Please note that the penalties and interest accrue automatically on bills when not paid within the time frame. Call your attention to CCR 9794(1) which provides that "The original procedure codes used by the physician or other provider shall not be altered".

AFFIDAVIT OF COMPLIANCE: Consistent with Rule 10606, I certify by my signature that the initial history was taken by _____. The history was reviewed by the undersigned with the patient present. The measurements were taken by _____, who was personally trained by me. The examination was performed by me. I dictated and proofread this report. I further certify that this report is my work product and describes and expresses exclusively my professional findings, opinions and conclusions on the matters discussed.

Consistent with Labor Code Section 4628, this evaluation was performed on the date listed above at my office at 10700 Santa Monica Blvd., Suite 309, Los Angeles, CA 90025. The time spent performing the evaluation was in compliance with the guidelines established by the administrative director pursuant to paragraph (5) of Subdivision (1) of Section 139.2 and the x-rays, if any, have been performed in my office by an x-ray technician, who is an employee of mine.

"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 I have indicated I have 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 declare under penalty of perjury that I have not violated Labor Code Section 139.3 and 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 any referred examination or evaluation. The contents of this report are true and correct to the best of my knowledge.

In compliance with recent Workers' Compensation legislation (Labor Code Section 9795): I declare under penalty of perjury that medical records included in this report total a number of 0 pages.

I declare under penalty of perjury that the foregoing is true and correct."

Executed on _____ at [redacted].

Sincerely,

Steven N. Brourman, M.D.
Diplomate, American Board of Orthopedic Surgery
Fellow, American Academy of Orthopedic Surgeons
Qualified Medical Evaluator
American Society for Surgery of the Hand
SNB/

This report was electronically signed.

Steven N. Brourman, M.D.

Diplomate of American Board of Orthopedic Surgery
Certificate for Added Qualifications for Surgery of the Hand
Fellow American Academy of Orthopedic Surgeons
American Society for Surgery of the Hand
Qualified Medical Evaluator
10700 Santa Monica Blvd., Suite 309 Los Angeles, California 90025

Date

[redacted]

PATIENT:
EMPLOYER: City of [redacted] Police Department
JOB DESCRIPTION: [redacted]
SOCIAL SECURITY #:
WCAB#:
CLAIM #:
D/INJURY:
D/EXAMINATION:

AGREED MEDICAL EXAMINATION

Dear Ladies and Gentlemen,

Pursuant to your request, I performed an Orthopedic Examination on Mr. _____ a __-year-old, right-hand dominant male, regarding his industrial injuries. This evaluation was taken at my office located at 10700 Santa Monica Blvd., Suite 309, Los Angeles, California 90025. The following is a summary of my findings from an office visit on _____.

He is currently not taking medication for pain.

This report represents a comprehensive Agreed Medical-Legal Evaluation. The charges are derived according to section 9795 of the labor code for medical-legal fees and includes the following number of pages for the medical records reviewed: 0 pages

Mailing Address:
14600 Sherman Way, Suite101A • Van Nuys, California 91405
TEL: (818) 815-3900 FAX: (818) 933-7550

Please be advised this is a medical-legal evaluation and this does not qualify for a PPO/ Network Discount.

PAST EMPLOYMENT:

He has worked for the subject employer for a little more than 23 years.

JOB DESCRIPTION:

In June [redacted] he began working for [redacted] Police Department as a [redacted].

The job duties entailed wearing a uniform with Sam Browne belt that held his gun, baton, pepper spray, handcuff, tazer, magazine and radio. In addition, he would wear a bullet proof vest. He would drive a patrol vehicle, making traffic stops, responding to 911 emergency calls, subduing, restraining and arresting suspects who could be disorderly, drunk or uncooperative, performing search and seizure activities, writing citations and reports, dealing with public disturbances and mediating disputes, seizing and handling evidence, conducting book procedures, searching for and chasing suspects over various terrain and obstacles, rendering emergency first-aid or CPR and all aspects of communication with community service agencies. He would qualify for weapons twice per month. For the last 14 years, he has worked in specialized unit and he wore tactical gear, helmet, and vest that weighed about 60-80 pounds. He had to do crowd control and serve search warrants.

The physical requirements consisted of prolonged sitting, standing and walking; repetitive bending, stooping and squatting; repetitive twisting, turning and reaching above and below shoulder level and waist level; repetitive arm and hand movement, simple and forceful grasping, torquing motions and fine finger manipulation. He lifted and carried from 150-200 pounds. He worked 10-14 hours per day, 4-6 days per week.

CONCURRENT EMPLOYMENT:

The applicant denies working for a concurrent employer or earning cash on the side for additional income.

SUBSEQUENT EMPLOYMENT:

He denies subsequent employment.

PERIODS OF TEMPORARY TOTAL DISABILITY:

In [redacted], he was off work for about 10 months due to his right knee surgeries. During this time period, he received workers' compensation benefits.

In [redacted] or [redacted], he was off work for a couple of months. During this time period, he received workers' compensation benefits.

He was off work from December [redacted] through July [redacted]. During this time period, he received workers' compensation benefits.

He was off work from November [redacted] to April [redacted]. During this time period, he received workers' compensation benefits.

CURRENT WORK STATUS:

He has been working regular duty for the subject employer.

HISTORY OF INJURY & TREATMENT:

Mr. [redacted] reports in approximately [redacted], he injured his right knee. He was playing basketball in the team and ruptured his ACL during a tournament.

He was examined and x-rays were obtained. Medication was prescribed. He underwent an MRI of the right knee and was told he required surgery. He underwent surgery of the right knee in approximately [redacted]. He received postoperative physical therapy.

He underwent an updated MRI of the right knee and was told he required another surgery, which was performed on an outpatient basis. He received postoperative physical therapy. He was off work for about 10 months.

He then returned to work regular duty for the subject employer. However, he still had pain in the right knee, but he was able to work.

In [redacted], he got into metro and injured his right knee from the training and running. He reported the symptoms to his employer.

He underwent an MRI of the right knee and was told he required meniscus surgery.

In [redacted] on [redacted], he underwent right knee surgery performed by Dr. [redacted] on an outpatient basis. He received postoperative physical therapy. He was off work for about a couple of months. He states that he felt a lot of better, because the surgery was much better.

He states that he had to do trial pushups, pullups and sit ups and 3 miles run every 3 months or twice per year.

In [redacted], he states that he did not swat trials and he gradually began to experience pain in the shoulders, but he felt he could work through it.

In [redacted], he injured his back and he was referred for medical care. He states that he retained legal counsel and he informed him of the right knee and bilateral shoulder pain.

He was referred to Dr. [redacted] He was examined and x-rays were obtained. He was referred for physical therapy.

He received 5 sessions of physical therapy for his right shoulder, which did not help with the pain.

He underwent an MRI of both shoulders and right knee. He was told he required right knee surgery and shoulders.

In December [redacted] he underwent right shoulder surgery performed by Dr. [redacted] on an outpatient basis. He received postoperative physical therapy. He was off work through July [redacted].

In November [redacted] he underwent right knee surgery performed by Dr. [redacted] on an outpatient basis. He received postoperative physical therapy for his right knee. He was off work through April [redacted].

He underwent a Synvisc injection of the right knee, which provided slight relief from the pain.

In approximately September [redacted], he underwent a PRP injection into the right knee, which provided relief for about 2-3 weeks.

He remains under the care of Dr. [redacted] and was last seen in September [redacted]. He asked him about the left shoulder surgery, but he was told he needed to finish treatment of the right knee. He has to call for a follow-up appointment.

He has been working regular duty for the subject employer.

He was taking ibuprofen, but he stopped as he developed ulcers that were found by an endoscopy and colonoscopy, which was recently performed. He was told he had gallstones and he might have to have the gallbladder removed.

He is currently not taking medication for pain.

CURRENT ORTHOPEDIC COMPLAINTS:

RIGHT SHOULDER: He experiences pain in his right shoulder, which is present most of the time. The pain increases with backward and overhead reaching. There is grinding and popping of the right shoulder. He cannot sleep on the sides, because his right hand goes numb.

LEFT SHOULDER: He experiences pain in his left shoulder all the time. The pain increases with forward, backward, lateral and overhead reaching and repetitive arm and hand movement. He cannot sleep on the left side, because it causes pain in the left shoulder and numbness and tingling in the left hand.

RIGHT KNEE: He experiences pain in his right knee which is present all the time. The pain increases with flexing, ascending and descending stairs, occasionally going from a seated position to a standing position and vice versa, prolonged standing and walking, bending, kneeling, stooping and squatting. There is swelling and grinding of the right knee.

ACTIVITIES OF DAILY LIVING:

The patient reports that he can look after himself normally with extra discomfort with performing activities of daily living or activities of self care. He reports problems with bathing and washing his hair, body and feet, dressing and putting on his pants, socks or shoes. He can do household activities and yard work, but with some difficulty. He can lift and carry heavy objects if they are conveniently positioned. He reports that his injury and discomfort prevent him from walking more than ½ mile. The most strenuous level of activities that he can perform for at least two minutes is very heavy activity.

He has some difficulty with climbing one flight of stairs. He has some difficulty with sitting for 30 minutes to one hour and a lot of difficulty sitting for up to two hours. He has a lot of difficulty standing and walking for 30 minutes to one hour and a lot of difficulty standing or walking for up to two hours.

He has some difficulty with reaching and grasping objects from a shelf located at eye level and some difficulty reaching and grasping objects located overhead. He has some difficulty with pushing or pulling activities. He has no difficulty with gripping, grasping, holding and

manipulating objects with his hands. He has no difficulty with performing repetitive motions such as typing and no difficulty performing forceful activities with his arms and hands.

He has a lot of difficulty with kneeling, bending or squatting.

He reports that his sleep is slightly disturbed since his injury and his sexual activities are not a problem.

He reports that his pain is moderate at the moment and moderate most of the time.

His pain does not interfere with his ability to travel and does not interfere with his ability to engage in social activities. His pain interferes some of the time with his ability to engage in recreational activities. He has problems with prolonged driving due to his right knee.

His injury and pain do not affect his ability to concentrate and think.

Per the patient, his injury and pain cause mild depression and anxiety, some of the time.

PAST MEDICAL HISTORY:

PREVIOUS WORKERS' COMPENSATION CLAIMS:

From [redacted] to [redacted], he was in the Marines, which caused pain in the low back. He did not get medical care.

He fractured his left ankle in [redacted] while in the Marines; he received medical care in the form of casting and physical therapy.

In [redacted], he injured his right hand while going over a fence. He received medical care including sutures and was hospitalized. He was seen by a hand specialist. He fully recovered. He did not recall if he got an Award for this claim.

In approximately [redacted], he filed a claim for his low back. He had to shoot on the range and he picked up his tactical vest and he felt pain in the low back. He was referred to [redacted] and given medication for pain. He received physical therapy and chiropractic treatment. He was off work for one month.

He was evaluated by Dr. [redacted] at [redacted]. He was referred for 12 sessions of physical therapy, which was performed. He underwent an MRI of the low back and was told that L5/S1 was degenerated. He also had an EMG/NCV. He was told he would need replacement in the

surgery. He was instructed to lose weight and strengthen his core. He was then released from care. He received an Award for this claim.

PRIOR NON-INDUSTRIAL INJURIES:

He denies having prior sports/personal injuries.

PRIOR BICYCLE/MOTOR VEHICLE ACCIDENTS:

He denies being involved in bicycle/motor vehicle accidents.

SUBSEQUENT NON-INDUSTRIAL INJURIES:

He denies having subsequent injuries.

PREVIOUS SURGERIES:

In [redacted], he had two right knee surgeries as noted in the history.

In [redacted] or [redacted], he had right knee surgery as noted in the history.

In December [redacted], he had right shoulder surgery as noted in the history.

On January [redacted], he had right knee surgery as noted in the history.

SOCIAL HISTORY:

He was born in [redacted], CA on December 20, [redacted] He is married and has three children, ages 18, 17 and 11. His older daughter has Type I diabetes. Currently, he lives with his wife and children.

ALCOHOL:

He seldom drinks alcohol.

SMOKE:

He does not smoke.

ILLICIT DRUGS:

He does not use illicit drugs.

FAMILY HISTORY:

His father died of a heart attack. His mother is [redacted]-years-old, and is in good health. He has [redacted] and [redacted], who are in good health.

PERSONAL HISTORY:

He completed 12th grade. Afterward, he received an Associate's degree.

He served in the Marines for 4 years.

He drives an automatic vehicle.

HOBBIES/SPORTS/OTHER INTEREST:

Previously, he enjoyed played basketball, which he no longer does. He used to run a lot, but it is limited. He still has to work out and maintain.

CURRENT MEDICATION/VITAMIN SUPPLEMENTS/MEDICATED LOTION:

He is currently not taking medication for pain.

REVIEW OF SYSTEMS

CONSTITUTIONAL:

The applicant specifically denied recent weight loss or gain, fever, chills, fatigue, weakness or other constitutional problems.

EYES:

The applicant specifically denied pain, redness, glaucoma or other eye problems.

He wears reading glasses.

EARS/NOSE/THROAT/MOUTH:

The applicant specifically denied ear infections, hearing loss, vertigo, sensitivity to noise, sinus pain, sore throat, gum disease, difficulty swallowing, hoarseness or other ears/nose/throat/mouth problems.

CARDIOVASCULAR:

The applicant specifically denied chest pain, high blood pressure, thrombophlebitis, palpitation, dizziness or other cardiovascular problems.

RESPIRATORY:

The applicant specifically denied shortness of breath, asthma, wheezing, chronic cough, bronchitis or other respiratory problems.

GASTROINTESTINAL:

The applicant specifically denied nausea, diarrhea, constipation, flatus, changes in bowel habits.

He has ulcers due to taking pain medication.

GENITOURINARY:

The applicant specifically denied frequent urination, blood in urine, painful urination, changes in urination stream, urinary retention, or other genitourinary problems.

INTEGUMENTARY:

The applicant specifically denied skin lesions, mole changes, nail changes, hair loss, change in breast or other integumentary problems.

MUSCULOSKELETAL:

The applicant specifically denied symptoms of gout, arthritis or other musculoskeletal problems.

NEUROLOGICAL:

The applicant specifically denied symptoms of seizures, memory loss, tremors, blackouts, paralysis, stroke, headaches or other neurological problems.

PSYCHIATRIC:

The applicant specifically denied depression, anxiety, stress, mood swings, panic attacks or other psychiatric problems.

ENDOCRINE:

The applicant specifically denied diabetes, high cholesterol, thyroid problems, heat or cold intolerance, increased thirst, goiter, feeling tired or sluggish or other endocrine problems.

HEMATOLOGICAL/LYMPHATIC:

The applicant specifically denied anemia, easy bruising, swollen lymph nodes, past transfusion or other hematological/lymphatic problems.

ALLERGIC/IMMUNOLOGIC:

The applicant specifically denies allergic reactions, hay fever, frequent infection, HIV-positive, hepatitis or other allergic/immunology problems.

ONCOLOGY/MALIGNANCIES:

The applicant specifically denies a history of cancer.

PHYSICAL EXAMINATION:

GENERAL:
HEIGHT: [redacted] feet [redacted] inches
WEIGHT: [redacted] pounds

The applicant is **right** hand dominant.

CERVICAL SPINE EXAMINATION:

Inspection:

There is no loss of the normal cervical lordosis, nor are there any other abnormal curvatures.
There is no visible deformity or step-off.
There is muscle spasm in the left trapezius musculature.

Range of motion of the cervical spine:

	1	2	3	Normal
Occipital Flex:	60°	62°	60°	Occ-T1=50°
T-1 Flexion:	20°	20°	20°	
Occipital Ext:	45°	45°	47°	Occ-T1=60°
T-1 Extension:	16°	16°	10°	
Occipital Right:	30°	33°	30°	Occ-T1=45°
R-Lateral Bend (T1):	16°	16°	16°	
Occipital Left:	35°	37°	35°	Occ-T1=45°
L-Lateral Bend (T1):	16°	16°	16°	
Right Occ Rotation:	70°	72°	72°	80°
Left Occ Rotation:	70°	72°	70°	80°

The applicant did not complain of increasing pain towards terminal range of motion.

Palpation:

There is muscle spasm of the left trapezius musculature.

Provocative Testing:

	RIGHT	LEFT
Spurling Test:	Negative	Negative
Adson's Test:	Negative	Negative

BILATERAL SHOULDER EXAMINATION:

Inspection:

There is no evidence of atrophy, hypertrophy or asymmetry bilaterally.
There is no erythema, cyanosis, or other color changes bilaterally.
There is no visible subluxation of the glenohumeral joints bilaterally.
There is no deformity of the clavicle or acromioclavicular joints bilaterally.

Range of motion of the shoulders:

	RIGHT	LEFT	NORMAL
Flexion:	180°	180°	180°
Abduction:	170°	170°	170°
External Rotation:	80°	80°	80°
Internal Rotation:	80°	80°	80°

The patient did not complain of increasing pain towards terminal range of motion.

There was not a painful arc against resisted abduction bilaterally.

Palpation:

There is anterior and posterior tenderness of both shoulders.

Provocative Testing:

	RIGHT	LEFT
Apprehension Test:	Negative	Negative
Posterior Apprehension Test:	Negative	Negative
Supraspinatus Test:	Negative	Negative
Yergason's Test:	Negative	Negative
Drop Arm Test:	Negative	Negative
Neer's Impingement Test:	**Positive**	**Positive**
Hawkins-Kennedy Impingement:	**Positive**	**Positive**
Roo's Test:	Negative	Negative

<u>BILATERAL ELBOW EXAMINATION</u>:

Inspection:

There is no visible deformity or asymmetry bilaterally.
There is no bursa edema, erythema, or warmth.

Range of motion of the elbow, as measured with inclinometer, is as follows:

	Right	Left	Normal
Flexion:	140°	140°	140°
Extension:	0°	0°	0°-10° hyperextension
Supination:	70°	70°	70°
Pronation:	80°	80°	80°

Palpation:

There is no tenderness to palpation of the joint articulations bilaterally.
There is no tenderness to palpation of the extensor attachment at the lateral epicondyle bilaterally.

There is no tenderness to palpation of the flexor attachment at the medial epicondyle bilaterally.
There is no tenderness to palpation of the olecranon bursa bilaterally.

Provocative Testing:

	RIGHT	LEFT
Tennis Elbow Tests:	Negative	Negative
Golfer's Elbow Test:	Negative	Negative
Tinel's @ Elbow:	Negative	Negative
Pronator Teres Test:	Negative	Negative
Elbow Flexion Test:	Negative	Negative

BILATERAL HAND AND WRIST EXAMINATION:

Inspection:

There are no visible deformities, masses, or asymmetry
There are no visible nodules or contractures
There is no intrinsic musculature atrophy

Range of motion of the wrists:

	RIGHT	LEFT	NORMAL
Extension:	60°	60°	60°
Flexion:	60°	60°	60°
Radial Deviation:	20°	20°	20°
Ulnar Deviation:	30°	30°	30°

Palpation:

There is no tenderness over the:
Scaphoid or lunate carpal bones
Wrist flexion/extension crease
Tendons of the abductor pollicis longus/extensor pollicis brevis in the first dorsal compartment
Carpometacarpal joints of the hand
Triangular fibrocartilage complex/ulnocarpal ligament /distal radioulnar joint

There is no popping or triggering of the finger flexor tendons

Provocative Testing:

	RIGHT	LEFT
Tinel's:	Negative	Negative
Phalen's:	Negative	Negative
Semmes-Weinstein:	Negative	Negative
Flick's	Negative	Negative
Finkelstein's	Negative	Negative
Durkan's median compression test:	Negative	Negative

Grip strength with Jamar Dynamometer:

RIGHT (dominant)	LEFT
57 kg	54 kg
56 kg	50 kg
55 kg	48 kg

Measurements of upper extremities:

	RIGHT	LEFT
Arm: (4" above elbow)	41 cm	40 cm
Forearm: (4" below elbow)	34 ½ cm	34 cm
Wrist:	18 ½ cm	18 ½ cm

THORACIC SPINE EXAMINATION:

Inspection:

There is no excessive kyphosis past the normal thoracic curvature.
There is no visible scoliosis.
There are no visible deformities or step-off.
Chest expansion is normal.
There is no muscle guarding/spasm present.

Range of motion of the thoracic spine:

	1	2	3	Normal
T-1 Flexion:	110°	112°	112°	T1-T12=60°
T-12 Flex:	80°	80°	80°	
T-1 R-Rotation:	30°	33°	30°	T1-T12=30°
T-12 R-Rotation:	16°	17°	16°	
T-1 L-Rotation:	35°	35°	37°	T1-T12=30°
T-12 L-Rotation:	16°	16°	17°	

The applicant did not complain of increasing pain towards terminal range of motion

Palpation:

There is no paraspinal musculature tenderness to palpation.
There are no palpable abnormalities.

GAIT:

The gait is not antalgic.
The applicant is able to walk on heels and toes.
The applicant ambulates without assistance of crutches/cane.

LUMBAR SPINE EXAMINATION:

Inspection:

There is no loss of the normal lumbar lordosis, nor are there any other abnormal curvatures.
There is no visible deformity, or step-off.
There is no muscle guarding/spasm present.

Range of motion of the lumbar spine:

	1	2	3	NORMAL
T-12 Flexion:	80°	80°	80°	T12-Sac=60°
Sac-Flex:	30°	33°	30°	
T-12 Ext:	23°	23°	23°	T12-Sac=25°
Sac Ext:	10°	10°	12°	
T-12 Right:	25°	25°	27°	T12-Sac=25°
Sac-Right:	10°	12°	12°	
T-12 Left:	20°	20°	22°	T12-Sac=25°
Sac-Left:	10°	10°	10°	

Straight leg raise is negative bilaterally.

The applicant did not complain of increasing pain towards terminal range of motion

Palpation:

There is no paraspinal musculature tenderness to palpation.

There is no tenderness to palpation of the spinous processes.
There is no tenderness to palpation of the bilateral sacroiliac joints.
There is no tenderness to palpation of the piriformis/gluteus groups bilaterally.
There are no palpable abnormalities.

Provocative Testing:

	RIGHT	LEFT
Piriformis Test:	Negative	Negative
FABERE Test:	Negative	Negative

BILATERAL HIP EXAMINATION:

Inspection:

There are no visible deformities or asymmetries.

Range of motion of the hips:

	RIGHT	LEFT	NORMAL
Flexion:	100°	100°	100°
Extension:	30°	30°	30°
Internal Rotation:	40°	40°	40°
External Rotation:	50°	50°	50°
Abduction:	40°	40°	40°
Adduction:	20°	20°	20°

There was no pain throughout the range of motion testing bilaterally.

Palpation:

There is no tenderness or swelling present at the hip joint bilaterally.
There is no greater trochanter tenderness to palpation bilaterally.

Provocative Testing:

	RIGHT	LEFT
Patrick's/Fabere:	Negative	Negative
Trendelenburg's Sign:	Negative	Negative

BILATERAL KNEE EXAMINATION:

Inspection:

The right knee shows well healed surgical scars.

Range of motion of the knees:

	RIGHT	LEFT	NORMAL
Flexion:	115°	115°	130°
Extension:	0°	0°	0°

There is no popping, crepitus, or locking during range of motion testing bilaterally.

There is no pain during range of motion testing bilaterally.

Palpation:

There is anterior tenderness of the right knee.

Provocative Testing:

	RIGHT	LEFT
Lachman's/Anterior Drawer Sign:	Negative	Negative
Posterior Sag/Drawer Sign	Negative	Negative
Valgus/Varus Stress	Negative	Negative
Rotatory Instability Testing:	Negative	Negative
Pivot-Shift Test:	Negative	Negative
McMurray's:	Negative	Negative
Apley's Test:	Negative	Negative

BILATERAL ANKLE AND FOOT EXAMINATION:

Inspection:

There is no edema or erythema present bilaterally.
There is no visible deformity/step-off bilaterally.
There is no pes planus or pes cavus present bilaterally.
There is no intrinsic atrophy noted.

Range of motion of the ankles:

	RIGHT	LEFT	NORMAL
Flexion:	40°	40°	40°
Extension:	20°	20°	20°
Inversion:	30°	30°	30°
Eversion:	20°	20°	20°

There was no pain throughout the range of motion testing bilaterally.

Palpation:

There is no tenderness to palpation bilaterally.
There are no palpable masses or deformities bilaterally.
There is no tenderness to palpation of the joints bilaterally.
Peripheral pulses are normal bilaterally.

Provocative Testing:

	RIGHT	LEFT
Anterior Drawer Sign:	Negative	Negative
Talar Tilt Test:	Negative	Negative
Thompson Test:	Negative	Negative
Morton's Test:	Negative	Negative

Lower Extremity Circumferences:

	RIGHT	LEFT
Thigh: (4" above patella)	55 cm	55 cm
Calf: (4" below patella)	43 cm	43 cm

NEUROLOGICAL EXAMINATION:

Mental Status:	Alert & oriented x 3, no deficits in general fund of information or concentration
CN 2-12:	Grossly Intact
Rapid Alternating:	No slowness or gross deficits in coordination bilaterally

Motor Exam:

	RIGHT	LEFT
Biceps:	5/5	5/5
Triceps:	5/5	5/5

Shoulder:	RIGHT	LEFT
Abduction:	5/5	5/5
Forward Flexion:	5/5	5/5
Extension:	5/5	5/5
Internal Rotation:	5/5	5/5
External Rotation:	5/5	5/5
Deltoid:	5/5	5/5
Wrist Extension:	5/5	5/5
Finger Abduction:	5/5	5/5
Hip Flexion:	5/5	5/5
Knee Extension:	5/5	5/5
Knee Flexion:	5/5	5/5
Plantar Flexion:	5/5	5/5
Dorsiflexion:	5/5	5/5

Deep Tendon Reflexes:

Triceps:	Brisk with no asymmetry
Biceps:	Brisk with no asymmetry
Patellar:	Brisk with no asymmetry
Ankle:	Brisk with no asymmetry

Sensory Exam:

Pinprick	Intact with no dermatomal deficits bilaterally
Light Touch	Intact with no dermatomal deficits bilaterally
Proprioception	Intact bilaterally

RADIOGRAPHIC STUDIES:

The following x-rays were obtained today in my office.

RIGHT SHOULDER SERIES (1 view) – Prior subacromial decompression and ACL degenerative changes on the right side.

LEFT SHOULDER SERIES (1 view) - The bony structures are of normal density. There is no fracture, dislocation or subluxation present. There is no soft tissue abnormality demonstrated.

RIGHT KNEE FINDINGS – (1-2 views, AP Stand A-P) Mild grade I narrowing of the medial and lateral joint line and there appears to be an ACL tunnel noted in the proximal tibia. The lateral joint line also shows osteophyte formation.

REVIEW OF MEDICAL RECORDS:

Medical records were not available for review at this time. Should medical records become available, please forward them to my office for my review.

DIAGNOSES:

1. Status post right redo anterior cruciate reconstruction in November [redacted], rule out residual internal derangement, right knee.
2. Status post right shoulder arthroscopy with residual impingement syndrome.
3. Status post right knee medial meniscectomy in [redacted].
4. Prior right ACL reconstruction in [redacted].

DISCUSSION:

Mr. _____presents for orthopedic evaluation of injuries sustained during the course and scope of his usual and customary job duties with the City of [redacted] Police Department as a police officer. I examined the patient in the capacity as an Agreed Medical Evaluator.

He is currently working in a full capacity despite his injuries. He notes that his treating physician's have discussed the use of Synvisc injections and PRP injections for his arthritic right knee. He has been working for his employer since [redacted].

Before answering the questions in the cover letter I need to review updated diagnostic testing. He will be sent for electrodiagnostic testing of the upper extremities to assess for a neurogenic

component to his pain. In addition, he is sent for MRI scans of the bilateral shoulders and knees as well as ultrasound studies of the bilateral shoulders and the right knee.

The diagnostic studies will provide substantial medical evidence to help determine if there are any abnormal objective findings of the body parts in question. Electrodiagnostic studies are the gold standard to diagnoses and determine the severity of neuropathic processes and nerve entrapments, such as carpal tunnel syndrome. (For example, a nerve study will determine if sensory or motor loss is mild, moderate or severe, and this information can then be used to provide the most accurate rating impairment in the AMA Guides, 5th Edition). MRI scans, ultrasounds and CT scans provide important information with a high level of specific anatomical detail about articular and soft tissue lesions. These objective tests then can be compared to the patient's subjective complaints and physical examination findings in order to formulate the highest quality opinion regarding impairment of the claimed injured body parts.

In order to be compliant with Labor Code 139.2, requiring a report be submitted within 30 days of examination, I have prepared an initial report.

Today's evaluation is considered preliminary.

Mr. _____ is scheduled to return in four weeks with the results of his work-up and medical records reviewed. At that time, I will issue a complete report to address the questions raised in the _____(date) cover letter prepared by _____.

Per California Code of Regulations § 9794 (a) (1), subjective complaints and physical findings during the evaluation warranted diagnostic testing in order to complete the evaluation. The medical records provided did not include adequate medical information.

Please note that the Division of Workers' Compensation has clearly stated that civil penalties will be assessed under State Labor Code Sections 129 and 129.5 if this bill is not paid within the time frame specified by the Labor Code. Please note that the penalties and interest accrue automatically on bills when not paid within the time frame. Call your attention to CCR 9794(1) which provides that "The original procedure codes used by the physician or other provider shall not be altered".

AFFIDAVIT OF COMPLIANCE: Consistent with Rule 10606, I certify by my signature that the initial history was taken by _____. The history was reviewed by the undersigned with the patient present. The measurements were taken by _____, who was personally trained by me. The examination was performed by me. I dictated and proofread this report. I further certify that this report is my work product and describes and expresses exclusively my professional findings, opinions and conclusions on the matters discussed.

Consistent with Labor Code Section 4628, this evaluation was performed on the date listed above at my office at 10700 Santa Monica Blvd., Suite 309, Los Angeles, CA 90025. The time spent performing the evaluation was in compliance with the guidelines established by the administrative director pursuant to paragraph (5) of Subdivision (1) of Section 139.2 and the x-rays, if any, have been performed in my office by an x-ray technician, who is an employee of mine.

"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 I have indicated I have 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 declare under penalty of perjury that I have not violated Labor Code Section 139.3 and 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 any referred examination or evaluation. The contents of this report are true and correct to the best of my knowledge.

In compliance with recent Workers' Compensation legislation (Labor Code Section 9795): I declare under penalty of perjury that medical records included in this report total a number of 0 pages.

I declare under penalty of perjury that the foregoing is true and correct."

Executed on _____ at [redacted].

Sincerely,

Steven N. Brourman, M.D.
Diplomate, American Board of Orthopedic Surgery
Fellow, American Academy of Orthopedic Surgeons
Qualified Medical Evaluator
American Society for Surgery of the Hand
SNB/

This report was electronically signed.

June 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

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

FOR: July 6, 2022, Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS JONATHAN C. GREEN, M.D. – INTERNAL & OCCUPATIONAL MEDICINE

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 Jonathan C. Green, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

The Disability Retirement Services Division engaged I.M.S Board Certified Physicians to discuss potential candidates for the LACERA Panel of Examining Physicians. I.M.S. manages a panel of board-certified physicians specializing in Medical-Legal and Workers' Compensation Evaluations. The I.M.S network includes expertly trained and highly skilled physicians within a variety of specialties. With locations throughout Central and Southern California.

Jonathan C. Green, M.D. is Board Certified in Internal Medicine with a subspeciality in Occupational Medicine. He received his medical degree from the Washington University, School of Medicine in 1976 and completed internal medicine residency at the University of California, San Diego and Advanced Training in Occupational Medicine at the University of Cincinnati. Dr. Green is a certified by the State of California as a Qualified Medical Examiner and Independent Medical Examiner and has 20 years of experience performing medical legal evaluation 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. Staff will also provide an overview of the Quality Control Questionnaire process and procedures.

On June 8, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Jonathan C. Green, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Jonathan C. Green, 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 12-28-21

Physician Name: Jonathan Green MD
Group Name: X

Primary Address: 8960 Willowgrove Ave. SANTEE, CA 92071

Primary Contact: LORI McCullough
Title: Business Manager

Telephone: 866-586-7667
Fax: 619-562-0452
Email: [redacted]

Secondary Address:

Telephone:
Fax:
Email:

PHYSICIAN BACKGROUND

Field of Specialty: (1) INTERNAL MEDICINE
Board Certification ☒ Yes ☐ No

Subspecialty: (2) Occupational Medicine
Board Certification ☒ Yes ☐ No

License # G-34530

Expiration Date: 3-31-22

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	15
IME	10
QME	20
Workers' Compensation Evaluations	20
Disability Evaluations	20
Med-Legal Reports	20

Current Practice	Time Spent (%)
Treatment	20
Evaluations	80
Research	
Teaching	
	100 %

currently decreasing treatment cases after 30 yrs of treatment

Performing Medical Evaluations for Public Organizations	☒Yes ☐No
Performing Medical Evaluations for Private Organizations	☒Yes ☐No
Please Names of Organizations: City + County LA Fire + Police ORANGE Co, Fire + Police	Riverside Co. San Bernardino Kern Co. Bakersfield State of Cal. Cal Fire

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 or 503.75 per MLES

Cancelled Exams that do not adhere to your stated policy:	Fee: $ Click or tap here to enter text.
Cancelled Hearings that do not adhere to your stated policy:	Fee: $ 1750/3500

if given less than 5 business days notification
(1750 half day, 3500 full day)

CORRESPONDENCE ADDRESS
8960 Willowgrove Ave.
Santee, CA 92071

SCHEDULING
Phone (866) 586-7667
(619) 562-1015
Fax (619) 562-0452

LOS ANGELES
1711 W. Temple Street
Suite 8668
Los Angeles, CA 90026

LA JOLLA
4180 La Jolla Village Dr.
Suite 260
La Jolla, CA 92037

IRVINE
16300 Sand Canyon Ave.
Suite 602
Irvine, CA 92618

REDLANDS
1835 W. Redlands Blvd.
Suite 120
Redlands, CA 92373

BAKERSFIELD
5001 Commerce Dr.
Suite 100
Bakersfield, CA 93309

JONATHAN C. GREEN, M.D.
Diplomate, American Board of Preventive Medicine
With Specialty in Occupational Medicine

Diplomate, American Board of Internal Medicine

LACERA

JAN 12 2022

Disability Retirement

January 05, 2022

LACERA
300 N. Lake Ave
Pasadena, CA 91101

RE: APPLICATION TO LACERA PANEL OF EXAMINATION PHYSICIANS

~~Good Day~~:

Our ~~o~~ffice is looking forward to working with ~~LACERA for all future~~ Disability Retirement Evaluations. All scheduling and correspondence will go through our business office which is located at:

8960 Willowgrove Ave
Santee, CA 92071

We have 5 different locations throughout California to help with scheduling closest to where the patient resides. Our locations are:

4180 La Jolla Village Dr, Ste#260, La Jolla, CA 92037
16300 Sand Canyon Ave, Ste#602, Irvine, CA 92618
1711 W. Temple St, Ste#8668, Los Angeles, CA 90026
9802 Stockdale Hwy, Ste#105, Bakersfield, CA 93311
1835 W. Redlands Bl, Ste#120, Redlands, CA 92373

Any questions you may, please feel free to contact me.

Thank you,

~~Lori McCullough~~
Business Administrator
Jonathan Green, MD
P - 866-586-7667
F - 619-562-0452
[redacted]@gmail.com

Name of person completing this form:

Print Name: Jonathan Green	Title: MD
Physician Signature: [signature]	Date 12-28-21

You may attach additional pages if necessary.

Revised: 12/8/21

JONATHAN C. GREEN, M.D.
Diplomate, American Board of Preventive Medicine in Occupational Medicine
Diplomate, American Board of Internal Medicine

Appointments:
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Santee, CA 92071

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REDLANDS
1835 W. Redlands Blvd., Suite 120, Redlands, CA 92373

BAKERSFIELD
5001 Commerce Dr., Suite 100, Bakersfield, CA 93309

I have multiple offices which makes it more convenient for the Applicants

JG

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8960 Willowgrove Ave.
Santee, CA 92071

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JONATHAN C. GREEN, M.D.
Diplomate, American Board of Preventive Medicine
With Specialty in Occupational Medicine

Diplomate, American Board
of Internal Medicine

Curriculum Vitae

JONATHAN C. GREEN, M.D.

Boards and Licensure

California Medical License, Number G34530

Diplomate, American Board of Internal Medicine
Diplomate, American Board of Preventive Medicine
with Specialty in Occupational Medicine

Qualified Medical Examiner, State of California, Division of Industrial Accidents
Independent Medical Examiner, State of California, Division of Industrial Accidents

Postgraduate and Medical Education

Purdue University, Lafayette, Indiana
B.S. degree with Highest Distinction, 1972

Washington University School of Medicine, St. Louis, Missouri
M.D. Degree, 1976

University of California, San Diego
Internal Medicine Internship, 1976-1977
Internal Medicine Residency, 1976-1979

University of Cincinnati, Cincinnati, Ohio
Advanced Training in Occupational Medicine
Completed Mini-Residency in Occupational Medicine, 1984–1986

Professional Experience

Practicing and Consulting Physician (self-employed)
1986–present

Hospitality Laser, San Bernardino, California (owner)
2006-2010

Occupational Medicine Resource Center, San Diego, California
Medical Director, 1986-2002

Industrial Medical Center, San Diego, California
Staff Physician, 1980-1986

Life Extension Institute Medical Group, San Diego, California
Staff Physician, 1979-1980

Kaiser Hospital and Clinics (part-time), San Diego, California
Department of Family Practice and Internal Medicine
Staff Physician, 1977-1980

Research Experience

Department of Preventive Medicine, Washington University School of Medicine
Area of Interest: Exercise Physiology, 1973

Department of Psychiatry, Washington University School of Medicine
Area of Interest: Adolescent Delinquent Behavior, 1972

Department of Internal Medicine, Hepatic Research Laboratory
Indiana University School of Medicine, 1971

Societies

Member, American College of Physicians
Member, American College of Occupational and Environmental Physicians
Member, American College of Preventive Medicine
Phi Beta Kappa
Alpha Omega Alpha
American Medical Association
California Medical Association
San Diego County Medical Society
California Society of Industrial Medicine and Surgery

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Diplomate, American Board
of Internal Medicine

Sample Report #1

June 17, 2

[redacted]

[redacted]

RE:
DATE OF INJURY: CT 01/11/ - 05/20/
EMPLOYER: City of [redacted]
CLAIM NUMBER:
DATE OF EXAMINATION: June 3,

AGREED MEDICAL EXAMINATION

, a [redacted]-year-old female, was seen for an Agreed Examination in my Los Angeles office.

This report is based upon a history, physical examination, and record review. Face-to-face time was 40 minutes. This report will be billed using the Code ML-201 with the AME modifier. I declare under penalty of perjury that I have reviewed 96 pages of records as part of this report.

HISTORY OF ILLNESS:

began working for the City of [redacted] Police Department in [redacted]. The patient told me that she had a severe accident in [redacted]. She told me that as a result thereafter she no longer worked in Patrol. She told me the last several years she worked recruitment. She did wear the gun belt until [redacted], she told me. The patient told me it was not, however, used or worn all 10 hours of her shifts. She clarified that she worked up until January 31, [redacted], for the [redacted]PD, and then beginning the following day, she worked for five years or so as a Reserve Officer. This was what she called "Level 1" where she would wear the belt as well. She told me she got a stipend, working about 16 hours a month. She told me that she also worked security for the [redacted] and for [redacted], but those were part-time jobs with no lifting or straining. The patient told me that she had years and years of wearing the gun belt with also four years of work in the bomb squad where she would be carrying about 110 pounds of gear on her.

With regard to internal problems, the patient told me that she has had left hip and groin pain for several years. She does not recall precisely when it started, but it worsened over time. She told me that she followed up with her doctor, and when she was checked for her hip, the doctor said that he thought she had a hernia as well. This was on the left side. This was in June of last year, [redacted]. The patient then went on to have a scan done, and it turned out she had hernias on both sides. The patient then went to her primary physician and then was referred to Surgeon [redacted]

Dr. [redacted] works out of the [redacted]. The patient then had a bilateral inguinal hernia repair August 6, [redacted]. The patient told me it took about a month or two to recover, and she was then released. She has not had any swelling. She told me that the right side is fine - she has no symptoms on the right side. She still has pain in the left groin though, as above, no swelling. She told me that recently she saw Dr. [redacted] who examined her and noted the patient also had groin pain. The patient stated that Dr. [redacted] said the pain was from the hip, but that she should be checked to make sure she was not having any more problems from the hernia repair. The patient said that the hip is the real problem. She has a nagging pain that is there 24/7.

The left groin hurts, particularly with rotation of the left hip. She has not had any particular problems with bearing down though she is not doing much in the way of lifting given the hip problem. She is able to do walking about three hours per week.

JOB DESCRIPTION:

The patient's job description is as above. The patient worked as a Police Officer.

WORK STATUS:

The patient retired as a Police Officer January 31, [redacted], and as a Reserve May 21, [redacted].

OCCUPATIONAL HISTORY:

Occupational history is as above.

PAST MEDICAL HISTORY:

The patient has had the usual childhood diseases.

The patient has a history of multiple orthopedic problems. She also has a history of bronchitis and pneumonia.

Surgical procedures include herniorrhaphy as above. Right knee, [redacted]. Back procedures, [redacted] and [redacted] Arthroscopic right knee also in [redacted]. When she was a child, she had an umbilical hernia repair and a right wrist surgery back in [redacted].

REVIEW OF SYSTEMS:

Review of systems is remarkable for positives as above.

FAMILY HISTORY:

The patient's family history is remarkable for multiple sclerosis. Mother passed at age 68.

SOCIAL HISTORY:

The patient is single. She was born in [redacted]. She is a nonsmoker. She drinks small amounts of alcohol. Exercise is limited due to the hip.

PHYSICAL EXAMINATION:

General: The patient is a very pleasant female.

Vital Signs: Height is [redacted] feet [redacted] inches. Weight is [redacted] pounds. Pulse is 55. Respiratory rate 12. Blood pressure 128/86.

Head: Head is normocephalic.

Eyes: Normal.

Neck: Supple without adenopathy.

Lungs: Normal.

Heart: Normal.

Abdomen: Soft, obese. Surgical scars noted. There is no tenderness nor bulge nor defect on the right side. There is reproducible pain with internal rotation of the left hip. The patient did complain of deep groin pain, left side. No defect, however, was noted on the exam.

RECORD REVIEW:

Workers' Compensation forms. I do see herniation with CT claim [redacted] There is also a CAT scan of the

abdomen and pelvis, June 17, [redacted] Bilateral inguinal hernias. Right side actually larger than the left, containing fat.

Additional claim forms.

Report by the late Dr. [redacted] This was from October [redacted]. This is an internal and pulmonary evaluation. I do not see hernia listed on the exam. Reflux disease. 6% Impairment. Insomnia 4%. Mitral valve prolapse 0%. Aortic regurgitation 7%. Cardiac arrhythmia 4%.

Also, various orthopedic reports, Dr. [redacted] These are back in [redacted] MD, also saw the patient. These are years ago. [redacted]. Again, I am double-checking these. These are all orthopedic. [redacted] Also, Dr. [redacted] from [redacted]. Again, these are postoperative arthroscopy, right knee. [redacted] Dr. [redacted] Dr. [redacted].

Next are notes, Dr. [redacted] May 10, [redacted] Rule out arrhythmia. Reflux disease. This is emergency room. Also, from [redacted] from [redacted] Myalgias, nausea, diarrhea, gastroenteritis, Dr. [redacted]. Nurse's notes, discharge.

Physical examination pre-placement. Patient is age [redacted] She weighed [redacted] pounds. Fit for duty. Other notes here are for minor problems. Pain in the eye with a corneal abrasion. This is [redacted] and healing. Also, superficial laceration, [redacted] a scalp contusion.

DIAGNOSIS:

Status post bilateral inguinal herniorrhaphies.

DISCUSSION:

----- was seen for an Internal Evaluation. as noted above, has a history of left hip pain with the patient also describing left groin pain. The patient did have a scan, as noted above, which showed bilateral inguinal hernias. went on to have surgery August 6, [redacted]. I will definitely need the records from the patient's surgeon, Dr. [redacted]. The patient did tell me that she was released after about two months. has no symptoms on the right side though she still has groin pain on the left side. The patient told me she recently saw Dr. [redacted] who sagely noted that the patient needed to be worked up in order to make sure she had no further problems with the hernia. At the time of my examination, June 3, [redacted], I did not detect a recurrent hernia. I was able to reproduce symptoms with rotation of the left hip which would point, again, to a left hip problem causing the groin pain.

However, to be absolutely sure, I believe we need to get an ultrasound done of the left groin. That will also help me in assessing Whole Person Impairment.

Thus, in order to finalize my opinion, I will need an ultrasound of the left inguinal region.

With regard to causation, the patient did her fair share of lifting in the years past though, more likely than not, wearing the gun belt over many years led to at least some portion of the hernia being caused by the patient's work activities. Recognizing there is a Presumption for herniation in Safety Officers, I do not believe there is data to rebut the Presumption in this case. The patient does have, as per the CAT scan, some relaxation of the pelvic musculature with fat in the hernia sacs though, again, wearing the gun belt over decades must also be considered a cause of the herniations.

DISCLOSURE STATEMENT:

In accordance with Labor Code Section 4628 (b), (c), and (j) and Article 25 Rule 10978, let it be known that an outline of this patient's history was obtained by me personally.

I certify that I composed and drafted this report, reviewed the history with the patient, reviewed any prior medical records received before the dictation of this report and performed the research necessary and, except where noted in the body of the report, administered all diagnostic tests cited. The opinions and conclusions represented within this report are mine alone. It is understood that a medical assistant will record vital signs, draw blood, perform EKGs, pulmonary function, or chest x-rays when necessary, as these are technical duties not typically performed by physicians. I will read and interpret the above studies. The opinions and conclusions represented within this report are mine alone.

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 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. I have followed the time guidelines put forth by the IMC. This statement is made under penalty of perjury.

Date of report: See above date on page.

Dated this [redacted] day of 6, ;

at [redacted] County, California.

Sincerely,

Jonathan C. Green MD

Jonathan C. Green, M.D.
Diplomate, American Board of
Internal Medicine

Diplomate, American Board of
Preventive Medicine with
Specialty in Occupational
Medicine

Qualified Medical Evaluator
State of California

JCG/mrb

cc: [redacted]

Attn:

PROOF OF SERVICE BY MAIL
C.C.P. 1013a
STATE OF CALIFORNIA, COUNTY OF SAN DIEGO

I am a resident of the county aforesaid: I am over the age of eighteen years and not a party to the within entitled action; my business address is: JONATHAN C. GREEN, M.D., INC.; 9625 Mission Gorge Road, Suite B2, Santee, California 92071.

On JUN [redacted], I served the AGREED MEDICAL EXAMINATION RE: [redacted] on the interested parties in said action, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail in Santee, California addressed as follows:

[redacted]

I declare, under penalty of perjury under the laws of the State of California that the forgoing is true and correct.

Executed on JUN 18 2021 at Santee, California.

Lori McCullough

CORRESPONDENCE ADDRESS
8960 Willowgrove Ave.
Santee, CA 92071

SCHEDULING
Phone (866) 586-7667
(619) 562-1015
Fax (619) 562-0452

LOS ANGELES
1711 W. Temple Street
Suite 8668
Los Angeles, CA 90026

LA JOLLA
4180 La Jolla Village Dr.
Suite 260
La Jolla, CA 92037

IRVINE
16300 Sand Canyon Ave.
Suite 602
Irvine, CA 92618

REDLANDS
1835 W. Redlands Blvd.
Suite 120
Redlands, CA 92373

BAKERSFIELD
5001 Commerce Dr.
Suite 100
Bakersfield, CA 93309

JONATHAN C. GREEN, M.D.
Diplomate, American Board of Preventive Medicine
With Specialty in Occupational Medicine

Diplomate, American Board
of Internal Medicine

Sample Report #2

December [redacted]

[redacted]

[redacted]

RE:

DATE OF INJURY: CT 01/10/ - 12/11/

EMPLOYER:

CLAIM NUMBER:

DATE OF EXAMINATION: December 15,

AGREED MEDICAL EXAMINATION

, a -year-old male, was seen for an Internal Evaluation in my Irvine office.

This report is based upon a history, physical examination, and record review. Face-to-face time was 35 minutes. This report will be billed using the Code ML-201 with the AME Modifier. I declare under penalty of perjury that I have reviewed 44 pages of records as part of this report.

HISTORY OF ILLNESS:

[redacted] began working for the County of [redacted] Sheriff's Department in [redacted] Currently, [redacted] is working his usual duties. The patient works as the Operations Deputy in the Courthouse. Currently, the job is mainly sitting. The patient does computer work. He told me he actually has been in the office setting for about 10 years. He said it is more sitting than standing. He did state that back in the day when he worked Patrol, he would have periods of time when he would be standing for hours on end. He did work Patrol in the [redacted] timeframe. The patient did start his County work in [redacted] working the jail lockup. He did tell me there was a lot of standing during that period of time. He finished that assignment in [redacted]. He then went to the Courthouse in [redacted] for about a year, and then went to Patrol for four years. In [redacted] he became a Bailiff, and that was mainly sitting work. He told me that he would work thereafter mainly in a sitting position though he would be standing as well though, again, he said in the last 10 years, it has been more office work. He clarified that he is working the Traffic Court.

With regard to internal problems, the patient told me he was diagnosed with varicose veins. He told me that he saw a Dermatologist as he has had discoloration to the top of his feet. He was told that he had a circulatory problem. The patient told me that, as he recollects, it was Dr. [redacted] who was concerned about the circulation. The patient told me he then had a duplex scan recently though he is not certain of the results. He does not have symptoms from the varicose veins. He does have, however,

itching of the feet. He has used compression socks as well. He has not had any type of blood clots to the leg. He has not had edema. He has not had a sense of heaviness of the legs after standing all day. He has not had direct trauma to the legs. He remains under dermatologic care.

JOB DESCRIPTION:

The patient's job description is as above.

WORK STATUS:

The patient is working his usual duties. He has had no lost time due to the history of varicose veins.

OCCUPATIONAL HISTORY:

Occupational history is as above.

Previously, the patient worked in construction and was a truck driver.

PAST MEDICAL HISTORY:

The patient has had the usual childhood diseases.

The patient has a history of orthopedic injuries in past. No history of diabetes.

Surgical procedures include right middle finger, [redacted] left, middle, and right trigger fingers, [redacted].

REVIEW OF SYSTEMS:

Review of systems is otherwise unremarkable.

FAMILY HISTORY:

The patient's family history is remarkable for high blood pressure and coronary disease.

SOCIAL HISTORY:

The patient is married. He has two children. He was born in [redacted] He is a nonsmoker. He drinks about 10 or 12 beers a week. Exercise would be golfing about twice a month.

PHYSICAL EXAMINATION:

General: The patient is a very pleasant male. Station and gait normal.

Vital Signs: Height is 5 feet 7 inches. Weight is 197 pounds. Pulse is 70. Respiratory rate 12. Blood pressure 125/80.

Extremities: Examination of the lower extremities reveals very superficial veins to the upper leg, thigh area, bilaterally. There is absolutely no evidence of cords. There are no ropey veins. There is no tenderness. No edema bilaterally. Homans' sign is negative bilaterally. There is discoloration to the top of the feet though no varicosities at all. There is no stasis. There is no ulceration.

Limb girth measurements: Right/Left

Quadriceps: 47 cm/47 cm

Calf: 37 cm/37 cm

RECORD REVIEW:

Progress note, Dr. [redacted] This is dermatologic. Last updated April 13, [redacted] Skin cancer screening. Rough spots on face and ears. Itchiness on top of feet. No history of legs DVT. Brown spots. Actinic keratoses. Rule out BCC. Atypical pigmented lesions. Tinea pedis on the feet (fungal infection). I do see reference to capillaritis/Schamberg's disease vs. Lichen Aureus on the right and left. No stasis dermatitis nor ulcerations. The doctor did state that there was 1+ edema. He did recommend compression stockings and an ultrasound. He indicated that the patient had athlete's feet, but the itching is due to varicose veins under the skin. This is not fungus. Also, seborrheic keratoses. Progress note, Dr. [redacted]. Does state updated April 13 though this is a different note. Looks like the intake. Four diagnoses but not the Schamberg's disease.

Report by the Agreed Examiner in Dermatology, [redacted] August 24, [redacted] Dermatologic exam references the papules. "There is no evidence of varicosities noted." (Emphasis mine. - JG) Diagnosed with post-inflammatory hyperpigmentation and keratoses. 6% Whole Person Impairment. Treatment recommendations.

Workers' Compensation forms.

Deposition of June 7, [redacted]. Admonitions and background. Prior injuries. Questioned on the finger and hand surgeries. Questioned on the back. Questioned on other orthopedic conditions. Page 38, varicose veins. Mentioned something about compression stockings. Rash on the feet. The doctor would be Alaiti. Currently working at the Courthouse. Questioned on activities.

DIAGNOSIS:

Superficial varicosities of the thighs, nonindustrial.

DISCUSSION:

was seen for an Internal Evaluation with regard to the Amended Application to include varicose veins. At the outset, I must state there is no clinical evidence here at all of varicose veins. I agree with Dr. [redacted] in that regard. The patient does have scattered superficial varicosities involving the thighs, but that is a very benign condition indicating basically "broken blood

vessels" rather than any type of industrial injury nor industrially-caused condition.

The notes from Dr. [redacted]s office indicate that [redacted] complained of discoloration of his feet and was felt to have Schamberg's disease/capsulitis. Capsulitis means inflammation of the superficial blood vessels. Dr. [redacted] recommended for that condition stockings and, for completeness, it appears he did recommend having a venous duplex study done. I would, of course, like to review the duplex study for completeness.

Dr. [redacted] did state to the patient, "You do have athlete's feet, but the itching is due to varicose veins under the skin." I am not sure what the doctor actually meant as there is no evidence, as Dr. [redacted] noted, of varicose veins involving the feet. Perhaps the doctor is referring to the capsulitis as a result of the Schamberg's disease.

At this point, however, there is no evidence of an industrial injury. Indeed, the only objective findings include "broken blood vessels" involving the thighs which would not be the result of prolonged standing nor any type of work-related activities.

I will submit a supplemental report after I have reviewed the ultrasound.

Deputy [redacted] can continue his usual duties at the present time.

DISCLOSURE STATEMENT:

In accordance with Labor Code Section 4628 (b), (c), and (j) and Article 25 Rule 10978, let it be known that an outline of this patient's history was obtained by me personally.

I certify that I composed and drafted this report, reviewed the history with the patient, reviewed any prior medical records received before the dictation of this report and performed the research necessary and, except where noted in the body of the report, administered all diagnostic tests cited. The opinions and conclusions represented within this report are mine alone. It is understood that a medical assistant will record vital signs, draw blood, perform EKGs, pulmonary function, or chest x-rays when necessary, as these are technical duties not typically performed by physicians. I will read and interpret the above studies. The opinions and conclusions represented within this report are mine alone.

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 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. I have followed the time guidelines put forth by the IMC. This statement is made under penalty of perjury.

Date of report: See above date on page.

Dated this [redacted] day of 12,

at [redacted] County, California.

Sincerely,

Jonathan C. Green, M.D.
Diplomate, American Board of
Internal Medicine

Diplomate, American Board of
Preventive Medicine with
Specialty in Occupational
Medicine

Qualified Medical Evaluator
State of California

JCG/mrb

cc: [redacted]
Attn:

PROOF OF SERVICE BY MAIL
C.C.P. 1013a
STATE OF CALIFORNIA, COUNTY OF SAN DIEGO

I am a resident of the county aforesaid: I am over the age of eighteen years and not a party to the within entitled action; my business address is: JONATHAN C. GREEN, M.D., INC.; 9625 Mission Gorge Road, Suite B2, Santee, California 92071.

On JAN [redacted] I served the AGREED MEDICAL EXAMINATION RE [redacted] on the interested parties in said action, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail in Santee, California addressed as follows:

[redacted]

[redacted] declare, under penalty of perjury under the laws of the State of California that the forgoing is true and correct.

Executed on [redacted] Santee, California.

Lori McCullough

June 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

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

FOR: July 6, 2022, Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
ROBERT B. WEBER, M.D. – INTERNAL MEDICINE &
CARDIOVASCULAR MEDICINE

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 Robert B. Weber M.D. be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

The Disability Retirement Services Division engaged Garland & Associates Medical Legal Public Relations & Marketing to discuss potential candidates for the LACERA Panel of Examining Physicians. Garland & Associates purpose is to develop referrals for treatment cases, medical legal evaluations, including, impairment for Workers' Compensation, fitness for duty evaluations, and independent medical examinations, and expert witness testimony. Their network includes expertly trained and highly skilled physicians within a variety of specialties.

Robert B. Weber, M.D., is Board Certified in Internal Medicine with a subspeciality in Cardiovascular Medicine. He received his medical degree from The Medical College of Wisconsin in 1974 and completed residencies at Saint Mary's Medical Center and The Hospital of the Good Samaritan and a clinical fellowship in cardiology at Huntington Memorial Hospital. Dr. Weber has 12 years' experience performing medical legal evaluations for both public and private organizations and served as certified medical consultant for Southern California Edison.

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. Staff will also provide an overview of the Quality Control Questionnaire process and procedures.

On June 8, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Robert B. Weber. M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Robert B. Weber, 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: ROBERT B WEBER, M.D.	Group Name: Click or tap here to enter text.
Primary Address: 12099 W. WASHINGTON BLVD., SUITE 300 LOS ANGELES CA 90066	
Primary Contact: ROBERT B WEBER	Title: M.D./PRESIDENT
Telephone: 310-558-9777 Fax: 310-558-9778	Email: [redacted]CLOUD.COM
Secondary Address: NOT APPLICABLE	
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: INTERNAL MEDICINE Board Certification ☒Yes ☐No	Subspecialty: CARDIOVASCULAR MEDICINE Board Certification ☒Yes ☐ No
License # G30439 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	2015	Treatment	25
IME	2010	Evaluations	75
QME	2012	Research	0
Workers' Compensation Evaluations	2012	Teaching	0
Disability Evaluations	2012		100 %

Med-Legal Reports	2010			

Performing Medical Evaluations for Public Organizations	☒Yes ☐No
Performing Medical Evaluations for Private Organizations	☒Yes ☐No

Please Names of Organizations: CALPERS, CITY OF LA, COUNTY OF SAN BERNARDINO, CITY OF SANTA MONICA, SANTA BARBARA COUNTY EMPLOYEES' RETIREMENT, METRO-MTA, CITY & COUNTY OF SAN FRANCISCO, COUNTY OF RIVERSIDE, SEDGWICK, GALLAGHER BASSETT, AIMS, SCIF, SIBTF, SOUTHERN CALIFORNIA EDISON, CERTIFIED MEDICAL CONSULTANT,

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).

CANCELLATION POLICY:

If a deposition is canceled fewer than eight (8) calendar days before the scheduled deposition date, the physician shall be paid a MINIMUM of one hour ($455) for the scheduled deposition.

Cancelled Exams that do not adhere to your stated policy:	Fee: $ **350.00 - NO SHOW**
Cancelled Hearings that do not adhere to your stated policy:	Fee: $ **$500.00**

Name of person completing this form:

Print Name:	Title:
ROBERT B. WEBER	M.D. / PRESIDENT
Physician Signature: Robert B. Weber, M.D. FACC	Date 12/23/2021

You may attach additional pages if necessary.

Revised: 12/8/21

CURRICULUM VITAE
Robert B. Weber MD., FACC, QME

EDUCATION HISTORY:

INSTITUTION / DATES	DEGREE	LOCATION
University of California 1966 - 1970	Bachelor of Arts	Los Angeles, CA
The Medical College of Wisconsin 1970 - 1974 (Graduated 5/26/1974)	Doctor of Medicine	Milwaukee, WI
Saint Mary's Medical Center 1974 – 1975	Internship in Internal Medicine	Long Beach, CA
Saint Mary's Medical Center 1975 – 1976	Residency in Internal Medicine	Long Beach, CA
The Hospital of the Good Samaritan 1977 – 1978	Residency in Internal Medicine	Los Angeles, CA
Huntington Memorial Hospital 1980 - 1982	Clinical Fellowship in Cardiology	Pasadena, CA

PROFESSIONAL and WORK HISTORY	DATES	ADDRESS
ROBERT B. WEBER, M.D., F.A.C.C. A Professional Corporation:		
Private Practice in Internal Medicine	Jan. 1979 – June 1980	Santa Monica, CA
Private Practice in Cardiology	Dec. 1982 – May 2014	Los Angeles & Beverly Hills, CA 90210
Private Practice in Cardiology	May 2014 – Present	4340 Overland Ave. Culver City, CA 90230
HOSPITAL AFFILIATIONS		
Cedars Sinai Medical Center		8700 Beverly Blvd., W. Hollywood, CA 90048

LICENSURE AND CERTIFICATION	**EFFECTIVE DATE**
○ CA Medical License	1975
○ DEA License	1975

LICENSURE AND CERITFICATION	**EFFECTIVE DATE**
• American College of Cardiology, Fellow	1977
• Certification of American Board of Internal Medicine	1977
• Qualified Medical Examiner	2012

Robert B. Weber, M.D., F.A.C.C.

Diplomate, American Board of Internal Medicine and
Subspecialty of Cardiovascular Disease

Mailing Address:
1680 Plum Lane
Redlands, California 92374
(909) 335-2323

[redacted]

SAMPLE REPORT #1

[redacted]

APPLICANT	:	[redacted]
EMPLOYER	:	
D/INJURY	:	
CLAIM NO.	:	
EAMS NO.	:	
EXAM DATE	:	May 27, [redacted]

INITIAL CARDIOLOGY PANEL QUALIFIED MEDICAL EVALUATION

Gentlepersons [redacted]

This is an **INITIAL CARDIOLOGY PANEL QUALIFIED MEDICAL EVALUATION,** performed in the County of Fresno at 1564 Shaw Avenue, Clovis, California 93611 on May 27, [redacted].

I performed this cardiology exam on [redacted], a 51-year-old woman. I am in receipt of an applicant's advocacy PQME letter undersigned by [redacted], Esq. providing by way of background that on January 22, [redacted] Applicant filed an Application for Adjudication of Claim for cumulative trauma period August 1, [redacted] through January 21, [redacted] for heart trouble to include PAD, hypertension and heart murmur pursuant to Labor Code Section 3212.2. On March 13, [redacted], her application was amended to include her left foot. Applicant is employed as a Correctional Counselor III and has been working at [redacted] since June 27, [redacted].

I am also in receipt of a letter undersigned by [redacted] Claims Representative, indicating that [redacted] has alleged an injury to internal organs and left foot on January 21, [redacted]. She was employed by Substance Abuse Treatment Facility, [redacted] as a Correctional Counselor III hired on July 27, [redacted] [redacted] is claiming cumulative internal organ damage to include Hypertension and cumulative trauma to her left foot to include Plantar Fasciitis caused by her normal duties as a Correctional Counselor. Hypertension is not a presumptive injury for [redacted] employees. I am requested to determine if there is end-organ damage to her heart and address

related consequences of that damage. I am requested to address apportionment with and without the presumption.

Ms. [redacted] states that she began her employment on July 27, [redacted] and that for the past approximately four and one-half years she has been stationed at [redacted] where she interacts with level 2-4 inmates. She describes her work as classifying and enrolling new inmates and that her duties include the requirement to be prepared at all times to respond to emergencies, as a code 3 level. She also occasionally is on-call to serve as a warden. She oversees 65 staff members.

HISTORY OF PRESENT ILLNESS

In early August [redacted], Ms. [redacted] began noting frequent tiredness and fatigue. She went to see her private medical doctor, Dr. [redacted], who usually found her blood pressure to be in the normal range. However, on that visit her blood pressure readings were found to be 140-160 systolic range. She does not recall the diastolic pressures. She developed increasing fatigue. She started walking more, approximately 30 minutes twice per week. She hadn't been to the gym for many months. She began experiencing pain in her heels and the pads of her feet for which she saw a podiatrist, Dr. [redacted] who diagnosed plantar fasciitis. He prescribed orthotics, but they were not covered by her insurance.

Ms. [redacted] goes on to state that she began noticing that her feet began swelling up to the calves of her legs and that she saw that her veins had become more prominent in her feet. She was seen by a vascular surgeon, Dr. [redacted], who obtained an ultrasound of the veins revealing that she had developed blood clots in both legs, up to her pelvis. On February 13, [redacted], she underwent a venous sclerosis procedure in her left leg and five days later she developed a new blood clot, a Deep Venous Thrombosis, for which she was started on the anticoagulant Eliquis. She was just taken off Eliquis last week. She had a repeat ultrasound of her leg veins and she was told that only approximately 10 percent of the clots remain in her veins. I requested Ms. [redacted] to attempt to recall whether there were any precipitating causes for her DVTs, such as prolonged sitting, as in a long flight, a long car trip, and the like. She stated that she had not done any prolonged sitting. She states that her DVTs in March [redacted] were complicated by blood clots that had gone to her lungs, pulmonary emboli. She states she developed microscopic hematuria, found by an urologist who sent her to get a pelvic CT study. She has an appointment for a follow up visit and to obtain the results on June 22, [redacted] when she is to go for a cystoscopy.

Ms. [redacted] states that she was referred to a cardiologist, Dr. [redacted], who on February 19, [redacted] performed a number of cardiac tests: A nuclear heart scan, a Holter monitor and an echocardiogram, all of which she was told came back normal. He did diagnose hypertension based on her blood pressure record and prescribed medication. Now her blood pressure is in the 120s over 70s.

Ms. [redacted] states that following her return to work after her very temporary total disability she has experienced more stress because of the apprehension regarding the COVID-19 pandemic. One staff member tested positive for the virus. There is increased staff anxiety and arguments among the staff, she has noticed.

PAST MEDICAL HISTORY

MEDICAL: In addition to above, she has been told that she has decreased kidney function. She has a history of obesity and obstructive sleep apnea. There is not a history of diabetes mellitus or hyperlipidemia.

OPERATIONS: The applicant had gastric sleeve placed several years ago. She had venous sclerosis recently.

MEDICATIONS: Irbesartan 150 mg daily, ibuprofen 600 mg as needed for pain and muscle ache, tramadol as needed for pain.

ALLERGIES: None known.

HABITS

She has never smoked cigarettes. She drinks alcohol socially.

FAMILY HISTORY

Her father is [redacted], has been treated for prostate cancer. Her mother is [redacted], has had breast cancer. One[redacted] age [redacted], has stage 4 prostate cancer.

REVIEW OF SYSTEMS

General: She had gained six pounds over the past six years and she's starting to lose them.

HEENT: She has occasional headaches, about three times per week. They occur behind the eyes and in her temples. She denies lightheadedness or dizziness. She has had LASIK procedures on her eyes.

Cardiovascular: She has occasional pressure on the chest relieved by taking deep breaths. It is sporadic, occurs at rest. Sometimes her heart pounds and she has

flutters. This occurs 1-2 times per month although has occurred 2-3 times per week sometimes. It is not sustained.

Pulmonary: She has shortness of breath if she walks approximately 50 yards briskly. Prior to August [redacted] she had been running up to three miles, usually five days per week. She denies cough or wheezing.

Gastrointestinal: She began to have constipation about two months ago. She has a bowel movement usually every other day. Until about two months ago she had the urge but could not defecate and sometimes would spend up to two hours in the bathroom. She has become constipated and sometimes can go without a bowel movement for at least three days. She has begun taking Milk of Magnesia for this. She has noted occasional bright red blood in the stool and on tissue paper about 3-4 times per month.

Genitourinary: She denies urgency or dysuria. History of microscopic hematuria as noted above.

Musculoskeletal: Hands feels asleep in the mornings, they also feel swollen. This goes away in the morning. She denies joint pain.

Neuromuscular: He has had numbness and tingling in her left foot.

Sleep Ms. [redacted] states that it takes long for her to fall asleep over the past approximately two months. She awakens from sleep once or twice.

Height/Weight: I requested Ms. [redacted] give me her height and weight. Height [redacted] inches, weight [redacted] pounds and a BMI of [redacted].

ACTIVITIES OF DAILY LIVING

I reviewed the questionnaire concerning activities of daily living with the applicant in which she describes varying degrees of difficulty in engaging across the range of physical activities, such as she can look after herself normally but has extra discomfort, she can only lift and carry light to medium objects, she cannot walk more than one mile because of her injury and discomfort. The most strenuous level of activity she can do for at least 10 minutes is moderate activity. She has some difficulty climbing one flight of stairs and has a lot of difficulty sitting for 40 minutes to an hour. She is unable to sit for two hours and has some difficulty standing or walking 30 minutes to an hour. She is unable to stand or walk for two hours. She has a lot of difficulty with pushing and pulling activities. She has some difficulty gripping, grasping, and holding and manipulating objects with her hands. She has a lot of difficulty with forceful activities with her arms and hands

as well as kneeling, bending and squatting. She describes her sleep as moderately disturbed since her injury. In regards to sexual activity since and because of her injury, she describes it as a little less frequent because of her injury.

EPWORTH SLEEPINESS SCALE

I reviewed the Epworth Sleepiness Scale with the applicant in which she scored a total of 15, abnormal.

DIAGNOSIS

1. Hypertension, controlled; no evidence for hypertensive heart disease based on echocardiogram of February 17, [redacted] demonstrating normal left ventricular wall thickness.
2. History of chronic bilateral lower extremity venous hypertension.
3. History of obesity class II.
4. Status post gastric sleeve procedure for obesity; March 20, [redacted].
5. History of obstructive sleep apnea; resolved following weight loss.
6. Constipation, recent onset.

PERIODS OF TEMPORARY TOTAL OR PARTIAL DISABILITY

The applicant stated that she was out on temporary total disability from February 19, [redacted] through March 22, [redacted].

DISCUSSION

The applicant filed an Application for Adjudication of Claim for heart trouble, to include PAD, hypertension and heart murmur.

Having reviewed the applicant's medical records, it is apparent that the applicant has never had PAD, since PAD is Peripheral Arterial Disease, and the applicant has had peripheral venous disease in the form of chronic bilateral venous hypertension, as documented by the vascular surgeon, Dr. [redacted]. Dr. [redacted] described it as "Idiopathic", meaning no apparent underlying cause.

Ms. [redacted] in her relating her history of present illness and past medical history gave the impression that she had suffered Deep Venous Thromboses in both legs. However, this is not supported by the medical records and neither is her statement suggesting that she had had blood clots to the lungs, called pulmonary emboli. It is highly probable that the applicant was not entirely clear on the nature of her lower extremity vascular disease.

The word murmur refers to a sound heard by physicians when listening to a patient's heart via a stethoscope. Murmur is a generic term describing a sound caused by blood flow in any area of the heart. The vast majority of murmurs are due to normal phenomena of blood flow in the heart and not due to any pathologic condition. Thus the term murmur does not designate any cardiac pathology or diagnosis and therefore is not subject to impairment rating. The applicant's echocardiogram performed on February 17, [redacted] was described as showing mild tricuspid regurgitation and trace mitral regurgitation. The technology employed in echocardiography, which utilizes Doppler to detect the blood flow direction and velocity in blood flow across the heart valves is extremely sensitive, so that in the majority of otherwise normal people a minimal amount of backward blood flow or regurgitation is detected by this technology, and therefore it is not unexpected that mild tricuspid regurgitation and trace mitral regurgitation would have been detected on the applicant's echocardiogram. This is not to be considered at all significant cardiac pathology. It is possible that the murmur heard by physicians may have been due to her tricuspid regurgitation. However, this is of no clinical relevance and it is in my opinion within a reasonable degree of medical probability that it is also of no medical-legal significance.

RESEARCH

In order to assist in the elucidation and discussion of the applicant's chronic lower extremity venous hypertension, I have referenced the medical literature:

The term Chronic Venous Disease is used when functional abnormalities such as venous valvular incompetence and/or venous obstruction are present of long duration and associated with symptoms and/or signs. Symptoms may include lower extremity tingling, burning, aching, pain, tightness, skin irritation, itching, heaviness, swelling, fatigue, or muscle cramps. Venous signs include dilated veins, leg/ankle edema, skin changes, or ulceration. Risk factors for developing chronic venous disease include advancing age, family history of venous disease, ligamentous laxity from prolonged standing, increased body mass index, smoking, sedentary lifestyle, lower extremity trauma, prior venous thrombosis, some heredity conditions, high estrogen states, and pregnancy. The proportion of the population suffering from obesity and chronic venous insufficiency is increased and obese patients are more likely to be symptomatic as a result of their venous disease. The proposed mechanism for increased incidence and severity of chronic venous disease in obesity is explained by raised intra-abdominal pressure in the obese, leading to greater reflux across the valves of the deep veins, increased vein diameter and venous pressures.

References:

1. Glovicski P, et al. The care of patients with varicose veins and associated chronic venous diseases: Clinical Practice Guidelines of the Society for Vascular Surgery and the American Venous Forum. Journal of Vascular Surgery 2011; 53:SS.

2. Wittens C, et al. Editor's Choice - Management of Chronic Venous Disease: Clinical Practice Guidelines of the European Society for Vascular Surgery. European Journal of Vascular and Endovasuclar Surgery 2015; 49:678.
3. O'Donnell TF, Jr., et al. Clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum - Management of venous leg ulcers. Introduction. General Vascular Surgery 2014; 60:1S.
4. A M van Rij et al. Eur. J Vasc Endovasc Surg, 2008 June

AOE/COE

I am requested to opine as to whether Applicant sustained injury AOE/COE to include PAD, hypertension and heart murmur. I have already discussed the "heart murmur" and explained why this should be dismissed. I have already discussed and explained that "PAD", should be changed to chronic venous disease and will address this accordingly.

With regard to the applicant's chronic lower extremity venous disease, in her case referring to chronic lower extremity venous hypertension, it is my opinion within a reasonable degree of medical probability that her chronic lower extremity venous disease is AOE/COE. I hold this view given that throughout the applicant's long career as a correctional officer/counselor the job description and duties involved prolonged standing. I demonstrated in my research how prolonged standing is associated with the development of lower extremity venous disease.

With respect to hypertension, it is my opinion within a reasonable degree of medical probability that the applicant's hypertension is also AOE/COE. I find this is so given that the applicant's career inherently involves a need to be frequently hypervigilant due to the ever present presence of danger due to violence perpetrated by inmates on each other as well as on colleagues and on the correctional officer/counselor. Chronic stress is a known contributor to the development and maintenance of hypertension.

MAXIMUM MEDICAL IMPROVEMENT/PERMANENT AND STATIONARY

It is my finding that with respect to the applicant's hypertension and chronic lower extremity venous disease she has reached maximum medical improvement/permanent and stationary status, as of the date of this evaluation, May 27, [redacted].

PERMANENT IMPAIRMENT RATING PER FIFTH EDITION AMA GUIDES

Turning to the AMA Guides Fifth Edition, Page 66, Table 4-2, where I find the applicant belongs in Class I in that she is asymptomatic; has normal blood pressure on anti-hypertensive medication and no evidence of end-organ damage. It is therefore my opinion that 3% impairment of the whole person is appropriate.

With respect to the applicant's lower extremity venous disease, I turn to the AMA Guides Fifth Edition, Page 76, Table 4-5, where it is my finding the applicant belongs in Class 1 in that she has not had intermittent claudication nor pain at rest, has had transient edema, supported by the most recent physical examination findings in the medical records indicating the absence of edema and on radiograph examination there has been dilation of veins, requiring vascular surgery. It is my opinion that as she does have some limitation in her activities such as limitation to standing and walking, as described in her activities of daily living review, that she belongs in Class 1 with 9% impairment of the whole person. The condition in my opinion does not merit Class 2 as she does not meet those criteria.

It is my opinion that this determination of impairment rating does not require the alternative Almaraz-Guzman analysis.

CAUSATION

With regard to impairment for hypertension, it is my opinion that causation is industrial given that it developed many years into applicant's career as a correctional counselor.

With regard to causation for impairment due to the applicant's chronic lower extremity venous disease, it is my finding that causation is industrial in that it developed in the course of her long career during which she has had prolonged standing. There is also a factor of non-industrial causation based on applicant's history of obesity, as explained in Research.

APPORTIONMENT

It is my finding that given the industrial causation for the applicant's hypertension based impairment, that apportionment is not applicable.
With regard to applicant's chronic venous disease, I apportion 45% to non-industrial and 55% to industrial causation. The non-industrial portion is due to the significant contribution of the applicant's obesity to her venous disease as explained based on research performed, within reasonable degree of medical probability. The 55% is apportioned to industrial and based on her long career in which standing is a prominent feature.

FUTURE MEDICAL TREATMENT

The applicant should be managed by an internal medicine physician with availability of a referral to a vascular surgeon at the discretion of the treating physician.

Thank you for referring this applicant for evaluation. Should you have any further questions, please do not hesitate to contact this office.

SOURCE OF ALL FACTS AND DISCLOSURE

The source of all facts was the history given by the applicant and review of the previous examiner's medical reports. I personally interviewed the applicant, performed the physical examination, reviewed the history with the applicant, reviewed the medical records provided, dictated this report and it reflects my professional observations, conclusions and recommendations. Face-to-face time conformed with DWC guidelines. 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 the information that I have indicated and received from others. As to this 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. Labor Code 139.3 was not violated. Assistance with preparation of this report was provided by Rapid Care, Record Summarizer, who was trained by Arrowhead Evaluation Services, Inc. Please note that all times listed reflect physician time spent, not staff time.

Date of Report: [redacted] Signed this _____ day of _____, [redacted] at [redacted] County.

Yours Sincerely,

Robert B. Weber, M.D., F.A.C.C.
Diplomate, American Board of Internal Medicine and
Subspecialty of Cardiovascular Disease

RBW/db

cc: [redacted]

Attached: Review of medical records

REVIEW OF MEDICAL RECORDS:
[redacted]

Pages Reviewed: 1404

Application for Adjudication dated [redacted] w/DOI: CT [redacted]. Peripheral artery disease and cardiovascular to include HTN and heart murmur, pursuant to labor code section 3212.2. Employed by [redacted] Substance Abuse Treatment Facility as a Correctional Counselor III.

[redacted] - Annual Physician Certification by [redacted], MD at [redacted] Medical. Pt here to have a form completed for physical fitness incentive pay. Vitals: Ht: 5'2". Wt: 160 lbs. BMI: 29. SpO2: 98%. Temp: 98.2. HR: 83. BP: 130/82. Plan: Form was completed for physical fitness incentive pay.

[redacted] - Office Visit by [redacted], MD. Pt presents for work physical. Vitals: Ht: 5'2". Wt: 161 lbs. BMI: 29. SpO2: 97%. Temp: 97.9. HR: 87. BP: 106/68. Dx: General medical exam for employment. Plan: Pt is cleared for employment and physical form is scanned into multimedia. RTC as needed.

[redacted] - PR-2 by [redacted], MD by [redacted] Family Practice Med Grp. Pt presents with blocked ear sensation that was severe and itchy. Had nasal congestion associated with HA. Postnasal drip for 1 day triggering cough. Moderate-to-severe facial pain frontal, behind eyes and sore throat, painful to swallow, scratchy and worse with cough, burns. Cough dry and productive of clear and green mucous, chest burns, wheezing, SOB. Frontal HA, throbbing, band-like around neck. Fever for one day better with Tylenol, sweats. Chills and sweats for 1 day. Tried OTC Tylenol. Vitals: Ht: 62". Wt: 164 lbs. BMI: 29.99. BP: 120/70. Temp: 99.6. PE: Apex, between 4th and 5th intercostals space PMI. Dx: Acute nasopharyngitis (common cold). Rx: Promethazine-Codeine Syrup6.25-10 mg/5 mL. To use Pseudoephedrine usual dose and nasal lavage. Acetaminophen and/or Ibuprofen as needed. F/u p.r.n.

[redacted] - B/L Digital Screening Mammogram with CAD by [redacted], MD at [redacted] Imaging Ctr.
Impression: Benign. There is no mammographic evidence of malignancy. A 1 year screening mammogram is recommended.

[redacted] - PR-2 by [redacted], NP. Pt c/o pain in both feet. Pt has some moles on the face that she wants removed. She has some bumps along the borders of feet and some aching in feet. PSH: Tonsillectomy. Vitals: Ht: [redacted]. Wt: [redacted] lbs. BMI: [redacted] BP: 124/82. PE: L hand reveals blackish gray discoloration under the skin between 1st and 2nd digits. Some flesh colored nodules which are soft and ranging in size from 3-6 mm, distributed around the heel at the base of foot B/L. Mild pes planus. Dx: 1) Pain in joint, ankle and foot. 2) Neoplasm of uncertain behavior of skin. Plan: Referral to dermatology and podiatry. Requested she remove make up in future visits regarding her skin.

[redacted] - Podiatric Evaluation by [redacted], DPM at [redacted] Foot Care. Pt has some bumps appearing on the inside and outside of both heels only when she is standing. Pt wishes to know what the bumps are. States she has started a running program and has noted that her feet have become excessively painful during running time. Vitals: Ht: [redacted]". Wt: [redacted] lbs. Pulse: 77. BP: 131/84. Temp: 97.0. PE: DP and PT 2/4 B/L. Superficial venous plexus fill time is less than 3 seconds. Positive TTP along muscle origin and distal course of the tibialis anterior and posterior tendons B/L. Laterally deviated hallux with dorsal medial eminence B/L. Dx: 1) Asymptomatic micro lipomas, B/L heels. 2) Tenosynovitis with myositis posterior tibialis anterior tendons B/L. 3) Hallux abductovalgus deformity B/L. 4) Pathological pronation B/L. Rx: Medrol Dosepak. Plan: Pt was placed on B/L day splints to help abate pathological pronation and to stabilize arch. Requested x-rays of B/L feet.

[redacted] - X-ray of R Foot interpreted by [redacted], MD at [redacted] Imaging Ctr. Impression: No evidence of acute fx or dislocation.

[redacted] - X-ray of L Foot interpreted by [redacted], MD at [redacted] Imaging Ctr. Impression: No evidence of acute fx or dislocation.

[redacted] - PR-2 by [redacted], MD at [redacted] Family Practice Med Grp. Pt with sharp pain R lower abdominal/pelvic groin. Pain is worse today. She is in significant distress. Had restless sleep. Had L ovarian cyst less than a year ago and was treated with OCP. Had uterine ablation and does not have periods. Has idiopathic hematuria, has vessel in bladder that bleeds. PSH: Tonsillectomy, cystoscopy in July [redacted], B/L tubal ligation, [redacted] and uterine ablation in [redacted]. Vitals: BP: 108/70. PE: Tenderness over McBurney's point with mild rebound pain. Tenderness decreases as you palpate inferior to McBurney's point. Dx: 1) Hematuria, unspecified. 2) Abdominal pain, RLQ. Plan: Advised to go to ER. She clinically does not sound like appendicitis, but as always must be ruled out. She does have h/o ovarian cyst on L side and pain seems to be out of the pelvis.

[redacted] - ED Note by [redacted], MD at [redacted] Med Ctr. Pt c/o shooting, stabbing RLQ abdominal pain. States pain began gradually 3 days ago and progressively worsened. States h/o kidney/bladder infections and L ovarian cyst states pain is different than that associated with those ailments. Pain is worse with any form of movement. Has been unable to sleep due to pain. Pain radiates down to R leg. Pain level 8/10. PSH: Tonsillectomy and tubal ligation. Vitals: (at 1601, sitting) Temp: 98.1. Pulse: 81. RR: 20. BP: 126/68. Pulse Ox: 99%. (At 1901, lying down) Pulse: 73. RR: 18. BP: 149/89. Pulse Ox: 100%. PE: Guarding; tenderness and rebound to RLQ. Positive Psoas sign. ED Course: Pt states pain is now 5/10, previously 8/10. Converses with eyes open. OB-GYN and general surgery consulted. Dx: Abdominal pain. Rx: Tylenol No.3 300 mg/30 g. Plan: Pt discharged home in stable condition.

[redacted] Consultation Note by [redacted], MD at [redacted] Med Ctr. Pt was sent over tot the ER by Dr. [redacted] for possible acute appendicitis. Pt has had mild suprapubic pain for 3 days. Has h/o one painful ovarian cyst. PSH: Cystoscopy, BTL and tonsillectomy. Vitals: Afebrile. Pulse: 81. Resp: 20. BP: 126/68. PE: Mild TTP in the suprapubic region. Dx: Abdominal pain, suprapubic, R ovarian cyst with small amount of fluid in the R hemipelvis. Suspect pt has ruptured R ovarian cyst. Plan: Recommended to f/u with GYN and pelvic u/s and full GYN exam.

[redacted] – Laboratory Rpt at [redacted] Medical Center. RBC (L) 4.15. HCT (L) 36.8. Sodium (L) 134. Chloride (L) 99. Urinalysis: Protein (A) 10. Blood (A) small. Urobilinogen (A) 2.0. Urine RBC (H) 14.

[redacted]- CT of Abdomen with Contrast interpreted by [redacted], MD at [redacted] Imaging Ctr.
Impression: Prominent follicle or small cyst in the R ovary. Tiny amount of free fluid in the R posterior pelvis. An enlarged or inflamed appendix is not convincingly seen. No inflammatory changes are seen in the RLQ of the abdomen. No free air. No evidence of intestinal or urinary tract obstruction and no stones. Liver, pancreas and spleen are normal. Small L renal cyst. Lung bases clear. No other acute abnormality. No objective abnormality to explain RLQ pain.

[redacted] - CT of Pelvis with Contrast interpreted by [redacted], MD at [redacted] Imaging Ctr.
Impression: Prominent follicle or small cyst in the R ovary. Tiny amount of free fluid in the R posterior pelvis. An enlarged or inflamed appendix is not convincingly seen. No inflammatory changes are seen in the RLQ of the abdomen. No free air. No evidence of intestinal or urinary tract obstruction and no stones. Liver, pancreas and spleen are normal. Small L renal cyst. Lung bases clear. No other acute abnormality. No objective abnormality to explain RLQ pain.

[redacted] - PR-2 by[redacted], MD. Pt is amenorrheic since an endometrial ablation. She was given some pain medication last week for her RLQ pain. At this point, she is much better. Dx: Small ovarian cyst which ruptured, symptoms are much better. Plan: It does not seem there is a need to put her on birth control pills. The trouble seems to be over at this point. If she has recurring difficulties, BCP for longer time would be useful.

[redacted] - PR-2 by [redacted], MD at [redacted]Family Practice Med Grp. Pt not feeling well, hands and feet swelling, hair loss x 6 months. Feeling hotter than normal. She is constipated, but this is normal for her. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted]. O2 sat: 98%. Temp: 98.3. HR: 64. BP: 112/60. Dx: 1) Fatigue. 2) Unspecified alopecia. 3) Premenopausal menorrhagia. Plan: CBC, TSH, CMP, vitamin D and B12, FSH and lipid panel ordered.

[redacted] - Laboratory Rpt at [redacted] Med Ctr. Vitamin D hydroxyl (L) 18. Chol/HDL ratio (L) 2.7.

[redacted] - PR-2 by [redacted] Pt presents for f/u on labs. Started to exercise and had significant myalgia the next day. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted]. O2 sat: 99%. Temp: 98.7. HR: 82. BP: 114/60. Dx: Vitamin D deficiency. Rx: Vitamin D tablet 2000 unit. Plan: Continue exercise. Check lab in 3 months.

[redacted] – Visit Note by [redacted], MD. Pt for evaluation and treatment of multiple skin lesions, particularly concerned about painful growth on central back, which drains foul-smelling material. Also requests treatment for persistent hyperpigmentation on face. Expresses concern about possibly enlarging pigmented lesion on dorsal L hand for at least 1 year. Has long h/o psoriasis mostly involving L elbow. Dx: 1) Atypical pigmented lesion on L hand. Biopsy is indicated to r/o melanoma. 2) Benign but symptomatic epidermoid cyst on back. 3) Melasma. 4) Localized psoriasis. Rx: Hydroquinone cream 4% and Diprolene gel to psoriatic patch. Plan: Diagnostic scoop shave biopsy on L hand using Lidocaine and Epinephrine followed by Monsel's and then Duoderm. Sun protection encouraged and sunscreen samples given. Pt given surgery appointment for excision of bothersome cyst.

[redacted] - PR-2 by [redacted] NP. Pt c/o HA, stiff neck. Facial pain when her jaw popped on R side followed by HA. Neck pain started the following day and progressively got worse. Today she can hardly move neck at work. Pt was involved in an MVA in June and saw chiro, has had periodic pains in neck but never this severe. Got better with massage and manipulation in the past. Medications: Vitamin D capsule 50,000 units. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted] BP: 122/82. Temp: 98.4. HR: 76. O2 sat: 99%. PE: Tenderness of entire C/S and trapezius muscles B/L. Flexes about 10 degrees. Dx: 1) Cervical sprain. 2) Unspecified TMJ disorders. Rx: Ibuprofen 600 mg, Flexeril 10 mg. Plan: Continue heat and massage. Referral to therapy for C/S.

[redacted] (3 visits) Physical Therapy Notes from [redacted] Med Ctr. Pt completed 3 sessions of PT for neck. Pain rated as 5-7/10. Continue PT as tolerated.

[redacted] – Annual Physician Certification by [redacted], PA-C at [redacted] Medical. Pt for work physical. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted]. BP: 106/82. Pulse: 80. Temp: 97.4. O2 sat: 99%. Dx: Pt is here for work physical and examination is normal. Plan: Pt is cleared. Physical form completed.

[redacted] - Visit Note by [redacted], MD at [redacted] Family Practice Med Grp. Pt c/o L elbow pain, L arm pain x 1 week. Current Meds: Ergocalciferol 50,000 units, Ibuprofen 600 mg, Flexeril 10 mg and Fish Oil 1000 mg. Vitals: Ht: 63". Wt: 180 lbs. BMI: 31.88. O2 sat: 98%. Temp: 99.7. HR: 75. BP: 122/80. PE: Tender at lateral epicondyle and slightly distally. Dx: 1) Lateral epicondylitis of elbow. 2) Vitamin D deficiency. Tx: Tendon injection with 1% Lidocaine, 0.5% Marcaine and Kenalog to L elbow. Plan: Advised to continue tennis elbow splint, Motrin as needed and ice when she feels it is inflamed.

[redacted] - Progress Note by [redacted], MD. Pt did have some improvement in pain lasting for 6 weeks and then pain started to increase. Developed some swelling of forearm and hand and fingers. C/o tingling to thumb and index fingers. Initially had some pain to lateral elbow area and now having pain to medial side as well. Current Meds: Naproxen. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted]. O2 sat: 98%. Temp: 98.3. HR: 81. BP: 120/80. Dx: 1) Medial epicondylitis of elbow. 2) Injury to ulnar nerve. Rx: Ibuprofen 400 mg. Plan: Referral to neurology, EMG/NCV.

[redacted] - PR-2 by [redacted] MD. Pt c/o not feeling well, has had fever, back hurts and chest hurting x 3 days. Tried Mucinex and Tylenol without improvement. L ear pain today. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted]. O2 sat: 96%. Temp: 99.3. HR: 75. Dx: Influenza with respiratory manifestations. Plan: No ASA. Isolate until no fever. Off work [redacted]

[redacted] - Annual Physician Certification by [redacted], MD at [redacted] Medical. Pt is here for work physical. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted]. BP: 118/88. Pulse: 82. Temp: 98.8. O2 sat: 99%. Plan: Pt is cleared. Physical form completed.

[redacted] – Laboratory Rpt at [redacted] Med Ctr. Eos (L) 0.5. Immature gran (H) 0.5. Vitamin D-25 hydroxy (L) 27.0.

[redacted] - Progress Note by [redacted], NP. Pt had onset of dysuria yesterday. Also had urgency and frequency. Has been drinking a lot more water for last 2 days. HA today and LBP. H/o pyelonephritis about 3 years ago. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted] O2 sat: 96%. Temp: 98.4. HR: 78. BP: 118/72. PE: Left CVA and mild suprapubic tenderness. Dx: 1) Dysuria. 2) Cystitis, acute. Rx: Cipro 500 mg. Plan: UA and culture ordered.

[redacted] – Urine Culture Rpt at [redacted] Med Ctr. Result: No growth after 36 hours.

[redacted] – Laboratory Rpt at [redacted] Med Ctr. Urinalysis: BLO (A) Large.

[redacted] - Progress Note by [redacted], MD. Pt can hear herself snoring. She catches herself waking up. Husband reports she is snoring. Pt feels tired during day and can fall asleep easily. Gaining weight, had labs with GYN. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted]. O2 sat: 97%. HR: 76. BP: 122/80. Dx: Fatigue. Plan: Needs sleep study. Split night study if in lab, snoring, breath holding, fatigue, non restorative sleep, daytime somnolence.

[redacted] - Diagnostic and CPAP Titration Polysomnogram Report by [redacted], MD at [redacted] Sleep Disorders Ctr.
Dx: Axis A: Severe obstructive sleep apnea. Axis B: Polysomnography with CPAP trial at 13 cm H2O (we used a medium, Fisher Paykel ESON mask as the nose-pressure interface. Heated humidification was used. Chin strap was not used.) Axis C: Associated medical diagnoses – obesity.

[redacted] - PR-2 by [redacted] MD. Pt would like to discuss getting referred to have a lap band procedure. Had chronic obesity her whole life. She has tried Phentermine in 2012. She is having stress incontinence with exercise. Vitals: Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted]. O2 sat: 96%. HR: 86. BP: 120/86. Dx: 1) OSA. 2) Obesity. Plan: Recommended nCPAP trial. Referral to general surgery to consult on lap band procedure.

[redacted] - Doctor's First Report by [redacted], MD at [redacted] Medical Clinic. DOI: [redacted]. Employer: [redacted]. While working at job site, slipped on a patch of black ice, lost footing and fell straight back, landed on L side of back and legs split apart, one was in front and the other in back. Hit elbow and shoulder while attempting to break the fall. Felt back twisting on landing. Also hit the back of head. C/o back pain, L ankle, L leg, L elbow, L shoulder, neck pain and L hamstring. Pain rated 9/10. Vitals: Ht: [redacted] Wt: [redacted]bs. BMI: [redacted]O2 sat: 99%. HR: 71. Temp: 98.4. BP: 143/82. PE: L sciatic notch tenderness. Posterior aspect tenderness. Limited ROM in all planes. Dx: 1) L ankle pain. 2) L shoulder pain. 3) Fall. Rx: Cyclobenzaprine and Naproxen. Off work remainder of shift. Modified duty from [redacted] with no lifting over 10 lbs. No pushing/pulling > 25 lbs.

[redacted] - PR-2 by [redacted], MD. Pt presented for sleep apnea. Using CPAP last 3 weeks. Gradually getting used to it. She was able to leave it on all last night. She is feeling good today. Only yawned once. More alert. Alternating between nasal pillows and mask. Likes some aspects of bath. Vitals: BP 130/80, Ht 63", BMI 36.17. Dx remains unchanged. Plan: Continue CPAP.

[redacted] - PR-2 by [redacted], MD. C/o L shoulder and thigh pain rated 1/10. Pt's condition is improving. Vitals: HR 64, BP 118/84. Dx remains unchanged. Plan: Regular duty. Discharged and no further tx required and no permanent impairment.

[redacted] - PR-2 by [redacted], MD – [redacted]. Pt presents for evaluation of obesity and possible bariatric surgery. Weight was 205 lbs at its peak. Pt currently is severely obese. Pt had been on Adkin's diet, Slim Fast, Weight Watchers, Sympathomimetics Phen-fen, Pondimin since [redacted], doctor-supervised diet, own diet and Fad diets. Vitals: BP 155/99. Pulse 89. Ttemp 98.3. Ht [redacted]". Wt [redacted]lbs. BMI[redacted] Dx: 1) Undiagnosed cardiac murmur. 2) Venous insufficiency-mild. 3) Stress incontinence-moderate. 4) Morbid obesity refractory to medical management. 5) OSA-severe. Plan: Recommended bariatric surgery, referred to Cardiology, Psych, OB-GYN, nutrition consult and GI for diagnostic upper endoscopy, manometry. Ordered CMP, lipid panel, CBC w/differential, hemoglobin A1c, iron, parathyroid hormone, TSH, vitamin B1, B5, B12 and D-25 hydroxy.

[redacted] – Laboratory Rpt from [redacted] Med Ctr. Result: SGPT (H) 37. IRON (L) 41. Iron Sat (L) 11.7. Total Bili (L) 0.3. Chol/HDL ratio (L) 3.2. Vit D, 25 hydroxy (L) 25.8. Vit B6, plasma (L) 16.9.

[redacted] - B/L Digital Screening Mammogram with CAD Interpreted by [redacted], MD at [redacted] Med Ctr.
Positive Findings: There are scattered fibroglandular elements in both breasts that could obscure a lesion on mammography. There is a benign intramammary node in R breast.
Impression: Benign. There is no mammographic evidence of malignancy. A 1 year screening mammogram is recommended.

[redacted] - Endoscopy Rpt Interpreted by [redacted]r, MD at [redacted] Med Ctr.
Positive Findings: Basal LES pressures were low measured at 4.2 mmHg. LES length was 2.2 cm which was slightly lower than normal and that is a nonspecific finding. Distal wave peristaltic amplitude was slightly increased at 167.8 mmHg which is a non-specific finding. Examination of the esophageal body revealed well-ordered peristaltic contractions. There were 70% double peaked swallows and 10% triple-peaked swallows, which is a nonspecific finding.

[redacted] - Surgical Pathology Consult Note Interpreted by [redacted], MD at [redacted] Associates.
Specimen: Gastric biopsies.
Final Dx: Stomach biopsies-Helicobacter pylori gastritis with: A) Severe chronic antritis. B) Numerous bacillary forms on Giemsa stain. C) Negative for malignancy.

[redacted] - Endoscopy Rpt Interpreted by [redacted] MD at [redacted] Med Ctr.
Positive Findings: Basal LES pressures were low measured at 4.2 mmHg. LES length was 2.2 cm which was slightly lower than normal and that is a nonspecific finding. Distal wave peristaltic amplitude was slightly increased at 167.8 mmHg which is a non-specific finding. Examination of the esophageal body revealed well-ordered peristaltic contractions. There were 70% double peaked swallows and 10% triple-peaked swallows, which is a nonspecific finding.

[redacted] - Pre-Operative H&P Note by [redacted], MD. Pt has been fighting a weight problem for most of her adult life. Vitals: BP 127/82, pulse 69, resp 16, temp 98.8. Wt [redacted] lbs. Ht [redacted]". BMI [redacted] PE: Mild B/L edema. Dx: 1) Morbid obesity, with a BMI of 37 refractory to medical management. 2) Medical problems caused or exacerbated by her obesity including sleep apnea, urinary stress incontinence, venous stasis disease and SOB with exertion. Plan: Pt will be taken to the operating room for laparoscopic, possible open vertical sleeve gastrectomy with EGD.

[redacted] - Operative Rpt by [redacted], MD at [redacted] Med Ctr. Pre-op Dx: Morbid obesity refractory to medical management. Post-op Dx: 1) Morbid obesity refractory to medical management. 2) Hiatal hernia. Procedure Performed: 1) Laparoscopic vertical sleeve gastrectomy. 2) Laparoscopic hiatal hernia repair. 3) Esophagogastroduodenoscopy.

[redacted] - Surgical Pathology Interpreted by [redacted], MD at [redacted] Associates.
Specimen: Partial Stomach.

Final Dx: 1) Stomach, partial resection-a) Mild superficial chronic inactive gastritis, mucosal edema, and recent nonspecific hemorrhage. B) No evidence of' active ulcer, transmural necrosis, glandular dysplasia or malignancy.

[redacted] - PR-2 by [redacted], MD at [redacted]. Generally overall feeling well. Current Meds: Naproxen 500 mg, Norco 5-325 mg, Omeprazole 40 mg and Prochlorperazine Maleate 10 mg. Vitals: BP 110/75. Pulse 83. Temp 97.7. Wt [redacted] lbs. Ht [redacted]'. BMI [redacted]. Dx: Normal examination post op. Rx: Ursodiol 300 mg. Plan: Advised regular exercise.

[redacted] – PR-2 by [redacted], MD. Pt is here for work physical. Vitals: BP 118/83. Pulse 81. Temp 98.2. Ht[redacted]. Wt [redacted] lbs. SpO2 97%. BMI [redacted]. BSA 1.83. Plan: Pt is cleared. Physical form was completed, signed and scanned into pt's chart.

[redacted] - PR-2 by [redacted], MD. Pt presents s/p sleeve gastrectomy 3.5 months. Overall feeling fantastic. Recent 33 lbs weight loss. Vitals: BP 119/75. Pulse 51. Temp: 98. Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted]. Dx: Post-gastric bypass for obesity s/p sleeve gastrectomy with improving or resolving associated comorbid conditions. Plan: Maintain regular exercise. Given dietary counseling. Advised pt to avoid snacking. Advised 2-3 small meals a day with high protein and low carb intake.

[redacted] - PR-2 by [redacted], MD. Pt overall feeling well. Good variety small diet. Will start to exercise now. Recently had 4.05 lbs weight loss. Vitals: BP 135/86. Pulse 62. Temp: 98.3. Ht: [redacted]". Wt: [redacted] lbs. BMI: [redacted] Dx remains unchanged. Plan: Recommended vitamins.

[redacted] - Ultrasound of Unilateral Venous Interpreted by [redacted], MD at [redacted] Medical Center.
Impression: Normal duplex examination of RLE veins.

[redacted] - PR-2 by [redacted], NP at [redacted] Family Practice Medical Group. Pt c/o cough, body aches and chest pain due to cough since Monday afternoon. Symptoms started with nasal congestion, sneezing, cough, and HA for 10 days, then okay for 3 days, except for cough. On Monday afternoon coughed so bad that she missed work. Reports coughing spells since then. Upper back and chest are burning, low grade fever, poor appetite, sore throat, R ear pain. Missed 3 days of work due to hacking cough, SOB, mild wheezes. Vitals Signs: BP: 122/76. Temp: 98.5. Ht:[redacted]'. Wt: [redacted] lbs. BMI [redacted] HR: 86. O2 Sat: 97%. Dx: 1) Bronchitis. 2) Pharyngitis. 3) RAD. Rx: Promethazine-Codeine Syrup, Albuterol Sulfate HFA Aerosol solution and Sucrets. Plan: Advised saline water gargles. Pt took Ibuprofen for HA.

[redacted] - Laboratory Rpt from [redacted] Medical Center. Potassium (L) 3.5. Cholesterol/HDL ratio (L) 2.5.

[redacted] - Progress Note by [redacted], MD. Overall feeling fantastic. Recently had 42 lbs weight loss. Vitals: BP: 120/78. Pulse: 61. Temp: 98.3. Ht: [redacted]. Wt: [redacted]lbs. BMI: [redacted] Dx remains unchanged. Plan: Recommended vitamins. Given dietary counseling pertaining to obesity and bariatric surgery.

[redacted] - X-ray of B/L Screening Mammogram with CAD Interpreted by [redacted], MD at [redacted] Medical Center.
Impression: Benign. There is no mammographic evidence of malignancy. A 1 year screening mammogram is recommended.

[redacted] - Office Visit by [redacted], MD at [redacted] Medical. Pt here for work physical. No complaints. Vitals: BP: 112/78. Pulse: 68. Temp: 98.7. Ht: [redacted]'. Wt: [redacted] lbs. O2: 100%. BMI [redacted] BSA: 1.78. Plan: Pt is cleared. Physical form was completed.

[redacted] - PR-2 by [redacted], NP. Pt c/o sore throat, loss of voice. 2 days without eating, unable to swallow, sips of clear, but painful, left work early today. Vitals: BP: 120/72. Temp: 97.8. Ht: [redacted]'. Wt: [redacted] lbs. BMI: [redacted] HR: 88. O2 Sat: 99%. Dx: 1) Laryngitis. 2) ETD. 3) Cough. Rx: Zithromax, Zyrtec D and Promethazine-Codeine Syrup. Plan: Salt water gargles, Lozenges, can thicken liquids if chokes. ETD exercise discussed. Fluids, rest and supportive care.

[redacted] - PR-2 by [redacted], NP. Pt presents for itchy red papules on the body. Tried Hydroxyzine, but not improving. New itchy papules on arms and legs, mild on torso/back. Has occurred in the past with stressors, she is aware this is a trigger but not able to control this. Not sleeping from intense itching. Vitals: BP: 122/70. T: 98.3. Ht: [redacted]'. Wt: [redacted]lbs. BMI: [redacted] HR: 71. O2 Sat: 99%. Dx: Urticaria. Rx: Prednisone and Zyrtec. Plan: Discussed pathology and Tx options. Requested ID and avoid other possible triggers along with stress. Hydration and rest.

[redacted] - X-ray of B/L Screening Mammogram with CAD Interpreted by [redacted] MD at [redacted] Medical Center.
Impression: Benign. There is no mammographic evidence of malignancy. A 1 year screening mammogram is recommended.

[redacted] - Laboratory Rpt from [redacted] Medical Center. Cholesterol/HDL ratio (L) 2.6.

[redacted] - Care Coordinator Nurse Note at [redacted] Medical Clinic. Pt presented today for consult regarding abdominoplaty, breast lift and brachioplasty.

[redacted] – Laboratory Rpt at [redacted] Med Ctr. CBC: WBC 3.67 (L). Immature Gran 0.00 (L). Chemistry: Iron Sat % 36.9 (H). Chol/HDL Ratio 3.4 (L).

[redacted] - PR-2 by [redacted], MD. Pt fell downstairs at home and head hit bench of kitchen table. Also hit L knee and elbow. Had neck pain and LBP at onset. Treated with rest, Tylenol and ice to back initially and switching to heating pad last night on neck. Has HA since injury. Had MVA 10 yrs ago, had whiplash and she recovered from that. She left work early because of pain. Had nasal congestion last night. Needs referral back to Dr. [redacted]. Gastric sleeve in March [redacted] and needs yearly f/u for labs. Her OSA resolved with weight loss from gastric sleeve. Had negative reaction to pain meds postop March [redacted]. Vitals: BP 126/88. Temp 97. Ht [redacted]'. Wt [redacted] lbs. BMI [redacted] HT 68. Oxygen sat 97%. Dx: 1) Sprain of neck. 2) Lumbar sprain. 3) Acute nasopharyngitis. 4) Bariatric surgery status. Rx: Skelaxin 800 mg, Tylenol 500 mg, Nasacort AQ. Plan: Apply ice/heat. Referral for PT, ROM stretching. Consider Tramadol if needed. Cold is viral, will be most contagious for next 2 days. Referred to Dr. [redacted] as she is needing insurance approval for f/u of gastric sleeve done in March [redacted].

[redacted] - Ultrasound of Renal and Bladder Interpreted by [redacted], MD at [redacted] Radiology Ctrs.
Positive Findings: R kidney measures 10.5 x 4.3 x 5.2 cm. R kidney demonstrates a stone in the upper pole of R kidney measuring 9 mm. Renal cortex measures 12 mm. L kidney measures 11.4 x 4.8 x 5.5 cm. L kidney demonstrates a cyst in the lower pole of L kidney measuring 2.8 x 2.0 x 2.0 mm. This is a Bosniak type I simple cyst. Renal cortex measures 1.7 mm. The bladder prevoid volume 83 cc's. Postvoid volume 0 cc. Ureteral jets seen B/L. There is a fibroid within the uterus.
Impression: Fibroid uterus. L renal cysts. R renal stone, which is nonobstructing.

[redacted] - PR-2 by [redacted], MD. Pt has onset of dysuria, frequency and urgency on [redacted] and seen in urgent care on [redacted] UA abnormal. Given pain meds IM and another IM tx and antibiotics. Renal US done. Started to feel better on [redacted] Started to get more L flank pain for the last 3 days with increase in frequency, urgency, fatigued and hot last night and started Pyridium again last night. Feels better today. Completed her course of antibiotics, 7 days of Bactrim. Has urgency last night and resolved today. She is having sharper L flank pain last 2 days, felt different than last week. Vitals: BP 126/80. Ht [redacted]'. Wt [redacted] lbs. BMI [redacted] HR 88. Oxygen sat 98%. Dx: 1) Acute cystitis without hematuria. 2) R renal calculus. 3) L renal cyst. Rx: Pyridium 200 mg. Plan: Ordered urine culture/colony, UA without microscopic. Increase hydration to reduce future stone formation. Add lemon to water to acidify her urine and dissolve stone.

[redacted] – Laboratory Rpt at [redacted] Med Ctr. Urine Culture/Colony: No growth after 36 hours.

[redacted] – Laboratory Rpt at [redacted] Med Ctr. Chemistry: Iron sat % 42.3 (H). Chol/HDL Ratio 3.1 (L). CBC: Eos Abs Cnt 2.0 (H).
Vit B6, plasma 16.9 (L).

[redacted] - Progress Note by [redacted], MD at [redacted] Surgery Associates Med Grp. Pt overall feeling well. Recent 41 lbs weight loss, excess body weight loss 53.2%. Describes eating about one cup of food at a sitting. Excessive snacking, but making good choices. Exercising erratically. Ideal weight was [redacted] lbs. Vitals: BP 148/85. Pulse 63. Temp 98.7. Ht [redacted]'. Wt [redacted] lbs. BMI [redacted] Body surface area 1.74. Dx: Post gastrectomy malabsorption. Plan: Recommended vitamins. Discussed importance of taking multivitamins with minerals and iron, B12 1000 mcg, calcium citrate 1500 mg with vitamin D3 daily. Dietary counseling given.

[redacted] - Bilateral Digital Screening Mammogram 3D/2D with CAD Interpreted by Thu T. Le, MD at [redacted] Med Ctr. Comparison is made to exam dated [redacted] mammogram and [redacted].
Positive Findings: There are scattered fibroglandular elements in both breasts that could obscure a lesion on mammography. There is a benign nodule in R breast.
Impression: Benign. There is no mammographic evidence of malignancy. One year screening mammogram is recommended.

[redacted] - PR-2 by [redacted], MD. Pt with complaints of fever, vomiting, nausea, body aches and diarrhea x2 days. Feeling better today. Last vomiting and diarrhea yesterday. Tolerating clear liquids. Had flu shot. Her family has had flu-like symptoms, last 3 weeks ago. Treated with Tylenol and NyQuil. Had Chinese food and had symptoms of abdominal cramps and diarrhea that started 11 hrs later. No one else ill who ate at same restaurant. Vitals: BP 136/80. Temp 97.9. Ht [redacted]". Wt [redacted] lbs. BMI [redacted]. HR 84. Oxygen sat 98%. Dx: Gastroenteritis. Rx: Zofran 4 mg. Plan: Encouraged sips of electrolyte liquids, BRAT diet when hungry, yogurt okay. Advance as tolerated. Off work from [redacted]

[redacted] - Adult Health Questionnaire at [redacted] Med Clinic.

[redacted] - PR-2 at [redacted] Med Clinic. C/o bladder infection since yesterday. Dysuria and pt has been taking Azo. Vitals: Ht [redacted]". Wt [redacted]. Temp 98. BP 132/84. Pulse 88. O2 97%. Rx: Bactrim DS.

[redacted] - Allergy List/Immunizations/Problems/Infusion Billing at [redacted] Imaging Ctr.

[redacted] - Medication Orders/Radiology Orders at [redacted] Imaging Ctr.

[redacted] - Family History/Social History at [redacted] Imaging Ctr.

[redacted] – B/L Digital Screening Mammogram 3D/2D with CAD Interpreted by [redacted], MD at [redacted] Imaging Ctr. Comparison is made to exams dated: [redacted] mammogram, [redacted] mammogram, and [redacted] mammogram at [redacted] Imaging Ctr.

Positive Findings: There are scattered fibroglandular elements in both breasts that could obscure a lesion on mammography. There is a benign nodule R breast.
Impression: Benign. There is no mammographic evidence of malignancy. A one year screening mammogram is recommended.

[redacted] - Allergy List/Immunizations/Problems/Infusion Billing at [redacted] Med Ctr.

[redacted] - Medication Orders at [redacted] Imaging Ctr.

[redacted] - Family History/Social History at [redacted] Med Ctr.

[redacted]- PR-2 by [redacted], PA-C at [redacted] Practice Med Grp. Pt c/o dysuria and frequency that began yesterday and back pain. Felt feverish last night. Admits to holding her bladder while traveling earlier this week. Started Azo this morning. History of pyelo x2, both came on very suddenly. Requests lab work. Vitals: BP 122/86. Temp 98. Ht [redacted]". Wt [redacted] lbs. BMI [redacted]. HR 73. Oxygen sat 97%. Dx: 1) Pyelonephritis. 2) Urinary frequency. 3) Dysuria. 4) Glycosuria. 5) Overweight (BMI 25.0-29.9). 6) Family history of type 2 DM. 7) Fatigue, unspecified type. Tx: Rocephin 1 gram IM. Rx: Cipro 500 mg and Pyridium 200 mg. Plan: Stay well hydrated, exercise regularly. Ordered UA without microscopic, CMP and lipid panel.

[redacted] – Laboratory Rpt at [redacted] Med Ctr. Urine Culture: No growth at 36 hrs verified on 03/03/19 at 13:26. No growth at 12 hrs verified at 03/02/19 at 13:51. Urinalysis without Microscopic: Glucose 100, BIL 3+/4. Ket +-/5. SG 1.030. BLO 1+. PH 5.0. Pro negative/Uro 2+/4. Nit positive. Leu 3+/500.

[redacted] - Allergy List/Immunizations/Problems/Infusion Billing at [redacted] Med Ctr.

[redacted] - Medication Orders/Laboratory Orders at [redacted] Imaging Ctr.

[redacted] - Family History/Social History at [redacted] Med Ctr.

[redacted] - Laboratory Rpt at [redacted] Imaging Ctr. Routine Chemistry: Chol/HDL 3.0 (L). Chol/HDL Fast 3.0 (L).
[redacted] - PR-2 at [redacted] Med Clinic. Pt's vision B/L 20/20, left 20/50, right 20/20 without glasses and left 20/25, right 20/20, B/L 20/20 with glasses. Presents for DMV physical. Vitals: Ht 62". Wt 157 lbs. Temp 97.9. BP 126/76. Pulse 65. O2 98%. BMI 28.7.

[redacted] - Medical Exam Questionnaire by [redacted] DO.

[redacted]- In-Office Urine Test Results. Ph 6.5. Blood trace. Ketones trace. Color yellow. Odor mild.

[redacted] - Urgent Care Office Clinic Note by [redacted], NP at [redacted] Urgent Care. Pt c/o L foot injury yesterday, struck big toe on step on street curb. She was on phone and was not watching where she was walking and kicked the curb. Pain is severe and +CMS, just pain on palpation and ROM. Vitals: Temp 36.7. HR 64. RR 20. BP 134/67. SpO2 100%. Dx: 1) L foot pain. 2) Injury of great toe. Rx: Meloxicam. Plan: Advised to use crutches and Ace wrap application. Ordered x-ray of L foot. Pt is discharged.

[redacted] - X-ray of Left Foot Interpreted by [redacted], MD at [redacted] Urgent Care.
Impression: Normal study.

[redacted] - PR-2 by [redacted], MD. Pt c/o rash on both legs x4 days. Noted red bump in right anterior tibia, got treatment for bugs. Worked in yard on [redacted] cleaning up and noted red bumps on legs on [redacted]. Initially her husband saw them and noted more on [redacted]. Areas start out small and then get larger, not raised. It is very itchy and worse at night. Treated with Benadryl, topical Cortaid 1%. Camomiln spray helps best. It is only on legs; mainly back. Having vasomotor hot/cold persistently, facial pigmentation on cheeks. Saw Dr. [redacted] prescribed topical "bleach" without benefit. Wants to see Derm in [redacted] and needs referral to podiatrist for foot pain and orthotics. Has visible veins on legs behind knees, family history of varicose veins. She will feel feet swelling end of day, cramps in legs. Running last one year on treadmill, but changed to street last 2 months. Lower leg pain after running now on street. Vitals: BP 142/80. Temp 98.6. Ht [redacted]'. Wt [redacted] lbs. BMI [redacted]. HR 72. Oxygen sat 98%. Dx: 1) Bug bite. 2) Melasma. 3) L foot pain. 4) R foot pain. 5) Asymptomatic varicose veins of BLE. Rx: Triamcinolone Acetonide cream 0.1%, Xyazl 5 mg. Plan: Apply cool compress. Requested consult with [redacted] Dermatology in [redacted]. Referred to podiatrist for B/L foot pain and Dr. [redacted] Vascular Surgery for the varicose veins. Stop running on road and return to treadmill. Recommended wearing compression tights during the day to help prevent worsening.

[redacted] - Urgent Care Office Visit Note by [redacted] NP at [redacted] Urgent Care [redacted]. Pt c/o L thigh pain since yesterday. Pain that is radiating ache, worse to back of LLE when sitting down. Vitals: Temp 37.1. HR 66. RR 18. BP 128/73. SpO2 99%. Dx: Sciatica. Rx: Baclofen, Diclofenac and Prednisone. Plan: Discharge pt.

[redacted] – Visit Note by [redacted], MD at [redacted] Dermatology Specialists. Pt c/o discoloration located on R cheek and L cheek. The discoloration is speckled and mixed-pattern and moderate in severity. She has had this discoloration for 5 years. Currently on Tretinoin, Hydroquinone and Differin and VI peel. Dx: 1) MIPS quality. 2) Melasma. 3) Rhytides. Plan: Pt is screened for tobacco. Ill-defined hyperpigmented patches in periorbital/malar distribution distributed on the face. Counseled about skin care. Discussed OBAGI kit, microneedling and laser treatment. Dynamic rhytides can be treated with Botulinum toxin.

[redacted] - Venous Insufficiency Duplex Exam from [redacted] Medical Group.

[redacted] - PR-2 by [redacted], DO at [redacted] Medical Group. Pt presents for B/L leg swelling, tenderness and tender reticular veins left worse than right. Wearing compression stocking, helped a little. Venous reflux testing shows severe bilateral GSV reflux. Current Meds: Vitamin D 1000 unit, Vitamin B12 100 mcg, Calcium. Vitals: Wt 147 lbs. BMI 26.98. BP: 111/74. HR: 74. Ht [redacted] cm. PE: Venous Reflux Duplex revealed abnormal study. Greater saphenous vein incomplete deep venous insufficiency lesser saphenous vein incompetence. Dx: 1) Chronic venous hypertension (idiopathic) with inflammation of LLE. 2) Swelling of BLE. 3) Chronic venous hypertension (idiopathic) with inflammation of RLE. Plan: Recommended continued stocking use and Venaseal treatment.

[redacted] - Urgent Care Office Clinic Note by [redacted] NP at [redacted] Urgent Care [redacted] Pt presents to clinic with complaints of coughing, congestion, and runny nose for approx 3-4 days. Current Meds: Albuterol 90 mcg, Baclofen 10 mg, Diclofenac Sodium 75 mg, Flonase 50 mcg, Ibuprofen 600 mg, Mobic 7.5 mg, Nyquil Cold & Flu, Oseltamivir 75 mg, Tylenol. Vitals: Temp 37.5. HR 79. RR 16. BP 141/90. SpO2 100%. Wt 68.5 kg. Dx: Type A influenza. Rx: Albuterol 1 puffs, Fluticasone nasal spray, Ibuprofen 600 mg, Oseltamivir 75 mg. Medical Decision Making: Well and non-toxic appearing. Discussed rest and hydration. Will take Tylenol for pain or fever. Pt will start BRAT diet should vomiting occur and resume regular diet as tolerated. Strict ED precautions given including worsening of symptoms. Pt verbalized understanding. Pt needs to be excused from work beginning now and through the following date [redacted]

[redacted] - PR-2 by [redacted], PA at [redacted] Family Practice Medical Group. Pt is here today to discuss fatigue and exertional SOB for 6 months. Feels tired all of the time. Exercise consists of walking 1.5 miles on her treadmill 3-4 time/week. Feels SOB right away, and after walking 15 steps at home. Used to jog miles w/o SOB. C/o tired, feeling fatigued, weakness, lightheadedness, feels like heart is going to explode. Napping often on the weekends. Bowel changes more constipated than usual. Has hemorrhoids which sometimes bleed bright red. Saw podiatry for new orthotics. Thought her leg and foot symptoms were due to her feet. Vascular surgeon found bilateral venous narrowing and is due for treatment of B/L legs . Was given knee high compression stockings. Vitals: BP 120/85. Temp 97.2. Ht[redacted]'. Wt [redacted]lbs. BMI [redacted] HR 67. Oxygen Sat 99%. Dx: 1) Chronic fatigue. 2) Exertional shortness of breath. 3) Exertional chest pain. 4) Chronic constipation. 5) Vitamin D deficiency. 6) History of weight loss surgery. Plan: Ordered labs. Referral to cardiology. Recommended ECG. Increase water intake, fiber and decaf fluids. Continue OTC vitamin D3.

[redacted] - Electrocardiogram at [redacted] Diagnostics Group.
Impression: Sinus rhythm. Within normal limits.

[redacted] - Allergy List/Immunizations/Problems/Infusion Billing at [redacted] Imaging Center.

[redacted] - Medication Orders/Orders at [redacted] Imaging Center.

[redacted] - Family History/Social History at [redacted] Imaging Center.

[redacted] - Laboratory Rpt at [redacted] Imaging Center. Result: CMP: BUN (H) 23. BUN/Creatinine Ration (H) 29. Chol/HDL (L) 2.8. Total Cholesterol (H) 210. Chol/HDL (L) 2.8.

[redacted] - Consult Note by [redacted], MD. C/o SOB for the last 8 months, usually while running, walking up 15 steps stairs, associated with palpitations. She used to run 3-1/2 miles a day but none for the last 3 months. Chest pain, sharp, stabbing, usually in R anterior chest, nonexertional. Six weeks ago, she also had bilateral leg edema, had bilateral venous disease and is going to get an intervention on legs. Home BP has been elevated, but she is not on any antihypertensive medication. In [redacted], she was seen by a cardiologist for preop cardiac eval and no abnormality was detected. PMH: Hypertension and heart murmur and GERD. PSH: Gastric sleeve in [redacted], endometrial ablation, hiatal hernia and abdominal lipectomy. Vitals: Ht [redacted] inches. Wt [redacted] lbs. BMI [redacted]. BP 152/94. HR 88. Oxygen sat 98%. PE: Heart: 2/6 systolic murmur at L sternal border. EKG revealed sinus rhythm. Dx: 1) Dyspnea. 2) Palpitations. 3) Chest pain, precordial. 4) Heart murmur. 5) HTN, essential. 6) Obesity. Rx: Losartan 150 mg. Plan: Recommended Holter monitor and treadmill stress test.

[redacted] - PR-2 by Kourtney E. Umphfres, PA. Pt is here today for her physical. Had her Pap in Jan. Saw cardiologist, Dr [redacted] yesterday for exertional SOB and more recent chest pain; started HTN meds and heart studies were ordered. Hasn't picked up meds yet. Had varicose vein reflux testing of left leg yesterday; scheduled in March for right leg. Right renal stone in February [redacted] per ultrasound, ordered due to frequent UTIs. Occasional has urine urgency and frequency with UTIs. Saw urologist 15 years ago for chronic blood in urine. Vitals: BP 130/83. Temp 97.3. Ht [redacted]". Wt [redacted] lbs. BMI [redacted]. HR 68. Oxygen sat 95%. Dx remains unchanged. Tx: Shingrix 0.5 ml, Adacel/Boostrix 0.5 ml. Plan: Ordered labs. Referral to urology and gastroenterology.

[redacted] - X-ray of Bilateral Digital Screening Mammogram with CAD Interpreted by [redacted], MD at [redacted] Imaging Center.
Positive Findings: There are scattered fibroglandular elements in both breasts that could obscure a lesion on mammography. There is a benign intramammary node right breast.
Impression: Benign. There is no mammographic evidence of malignancy A 1 year screening mammogram is recommended. ([redacted]). The patient was notified of the results.

[redacted] - Allergy List/Immunizations/Problems/Infusion Billing/Medication Orders/Orders/Family History/Social History at [redacted] Imaging Center.

[redacted] - Laboratory Rpt. Result: Urinalysis: Normal.

[redacted] - Urgent Care Office Clinic Note by [redacted], NP at [redacted] Urgent Care [redacted]. Pt c/o of lump to R side of her neck. Pt states that she got the shingles vaccine yesterday and today she developed a lump to right side of her neck. States that she had a vein mapping procedure 2 days ago on left leg and is scared of getting blood clots. States that the lump is swollen and painful to touch. C/o right arm and leg pain. Current Medications: Albuterol 90 mcg, Baclofen 10 mg, DayQuil Cough 15 mg, Diclofenac Sodium 75 mg, Flonase 50 mcg, Ibuprofen, Mobic 7.5 mg, Nyquil Cold & Flu. Vitals: Temp 37.6. HR 79. RR 18. BP 134/85. SpO2 99%. Dx: Enlarged lymph node. Plan: Take meds as directed. Reviewed discharge treatment plan and f/u instructions.

[redacted] - PR-2 by [redacted], MD. Presents for echocardiogram results. Dx remains unchanged. Echocardiogram revealed LVEF 65%. Mild tricuspid. Trace mitral regurgitation.

[redacted] - PR-2 by [redacted], MD. Pt presents for Holter Monitor results. Current Meds: Irbesartan 150 mg. Holter Monitor rpt revealed sinus rhythm. No dysrhythmia. No atrial fibrillation. No pauses > 2.0 seconds.

[redacted] - PR-2 by [redacted], MD. Pt presents for treadmill stress test results. Dx remains unchanged. Plan: Lexiscan result revealed no symptoms, no ST changes and perfusion. No ischemia. No infarction. LVEF rest 53%. Post stress 62%.

RBW/rpc
[redacted]

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[redacted]

SAMPLE REPORT #2

EXAMINEE	:	[redacted]
DATE OF BIRTH	:	
CalPERS ID	:	
EXAM DATE	:	

INDEPENDENT CARDIOLOGY MEDICAL EXAMINATION

Gentlepersons:

I performed a **CARDIOLOGY INDEPENDENT MEDICAL EXAMINATION** on Mr. [redacted] on July 6, [redacted], at my Fontana office located at 9161 Sierra Avenue, Suite 114, Fontana, California 92335.

I am in receipt of a letter from [redacted] indicating that [redacted] was employed by the [redacted] Highway Patrol as an Officer with allegations of chest pain, high blood pressure and difficulty breathing. This examination is being performed as part of an Industrial Disability Retirement Application.

Mr [redacted] began his career with [redacted] Highway Patrol as a [redacted] police officer on November 22, [redacted] and retired on May 26, [redacted].

HISTORY OF PRESENT ILLNESS:

Mr [redacted] states that he was first told he has hypertension in [redacted] when he developed chest pain radiating down his left arm and prompting him to present to the emergency room at [redacted] Hospital where he was evaluated and initially his blood pressure was 160/93. He was evaluated with stress testing and was told that his testing turned out well and that the chest pain was not cardiac in origin. He was placed on medication and Mr [redacted] states that his blood pressure did well. In [redacted], when he noted that his blood pressure continued to do very well he attributed it, in addition to his medications, to major lifestyle changes in the form of diet and

exercise, he discontinued his blood pressure medicines and his blood pressure remained controlled. Blood pressure readings then were in the 130s over mid-70s.

In January [redacted], a new captain was assigned to the [redacted] office, Mr. [redacted]' home base, who instituted new policies which had the effect of disrupting the atmosphere among the officers and leading to a marked increase in overall stress experienced by Mr. [redacted]. Mr. [redacted] said that in the latter part of February [redacted] he had a recurrence of chest pain prompting him to be seen at the emergency department at [redacted] Regional Hospital where he was diagnosed with unstable angina and admitted for further evaluation. He ultimately underwent a cardiac catheterization after which he was told by the cardiologist that he had essentially normal coronary arteries and reassured him as to the non-cardiac cause of his chest pain. He was discharged from the hospital three days later on a number of antihypertensive medications. His blood pressure came under control again with medications, so that his blood pressure typically would be in the 130s over 70s and this became the pattern again. Mr. [redacted] goes on to state that his blood pressure remained at that level and only rose when he would have any encounter either in-person or telephonically with any of his superior officers at which point his blood pressure would rapidly rise to the 160s and even up to the 180s systolic. He describes the context of his reactions to these encounters as having stemmed from the new and toxic environment that had been created at the station, adding that he is aware that a number of other officers are planning to transfer to other locations and actually a number have transferred. Mr. [redacted] goes on to state that this occurred over and above the new anti-peace officer environment that he and his fellow officers have been experiencing in the community. Mr. [redacted] goes on to summarize by saying that he found himself in a hostile environment both at work and out in the community.

He continues to experience chest pain primarily during episodes of anxiety. He has limited his physical activity for many years due to multiple orthopedic injuries so that he does not have any exertional dyspnea. He does not have any orthopnea or paroxysmal nocturnal dyspnea or pedal edema.

PAST MEDICAL HISTORY:

MEDICAL: Hypertension. He was diagnosed with obstructive sleep apnea in [redacted] and has been on CPAP. He denies diabetes. He was recently told that he has high cholesterol.

OPERATIONS: Tonsillectomy, deviated nasal septal surgery and left hernia surgery.

MEDICATIONS: Hydrochlorothiazide 12.5 mg daily, metoprolol 12.5 mg daily, losartan 50 mg daily and amlodipine 10 mg daily and aspirin 81 mg daily.

ALLERGIES: None known to medications.

HABITS:

He does not smoke cigarettes. He drinks alcohol socially averaging slightly more than one per day on a weekly basis. He drinks one cup of coffee daily. He does not drink tea or soft drinks.

FAMILY HISTORY:

His father is 85 and is healthy. His mother is [redacted] and has hypertension. He has two brothers ages 59 and 41 who are in good health.

REVIEW OF SYSTEMS:

General: He has gained [redacted] pounds in the past year due to inactivity.

HEENT: He denies headaches, lightheadedness or visual changes.

Cardiovascular: See above.

Pulmonary: He denies shortness of breath, cough or wheezing.

Gastrointestinal: He denies symptoms of GERD or dyspepsia, chronic constipation or diarrhea.

Genitourinary: He denies nocturia, dysuria or sexual problems.

Musculoskeletal: He has pain and stiffness in the hips, waist, knees, neck and back.

Neuromuscular: He has had numbness in the left leg and left hip area. He denies weakness.

Hematological: He denies anemia, easy bruising, bleeding or blood clots

PHYSICAL EXAMINATION:

General: Well-developed, obese appearing, middle-aged man. Pulse 100 and regular, blood pressure 150/106 in right arm and 167/94 in left arm, respirations 18 per minute, height [redacted]', weight [redacted] pounds, BMI [redacted] temperature 97.5 degrees, oxygen saturation 99% in room air.

HEENT: Pupils equal, round and react to light.

Neck: Without jugular venous distention or bruits. The carotid pulses display normal upstroke.

Lungs: Clear to auscultation.

Heart: Regular rhythm, there is an S4, no S3 or murmur.

Chest Wall: Light palpation reveals no tenderness.

Abdomen: Protuberant, soft and non-tender, no gross organomegaly or masses.

Extremities: 2+ edema bilaterally, pulses are normal.

Neurological: Grossly physiologic.

DIAGNOSIS:

1. Hypertension, sub-optimally controlled
2. History of hypertensive heart disease, consider left ventricular hypertrophy due to obesity.
3. Obesity class III.
4. Obstructive sleep apnea, on CPAP.
5. Hyperlipidemia.
6. Lower extremity edema, likely due to amlodipine.

DISCUSSION:

Answers to specific questions:

1. **Does the member/examinee have an actual and present cardiologic (chest pain, high blood pressure and difficulty breathing) impairment that arises to the level of substantial incapacity to perform their usual job duties?**

   Answer: The member has hypertension that, per his self-reporting of blood pressure readings as well as review of the medical records, has been sub-optimally controlled. The review of medical records reveals, furthermore, that the member has been noted to be unclear on what antihypertensive medicines he has been prescribed and at what dose he should be taking them, and this may be a factor in the suboptimal control of his hypertension to date. Hypertension, by itself, does not cause incapacitation to perform the member's usual job duties unless the blood pressure remains significantly elevated in spite of documented, consistent, and correct adherence to the medication regimen prescribed. With the number and choices of antihypertensive medications available, the vast majority of patients can achieve adequate blood pressure control.

2. **Considering the member's subjective complaints and the objective findings (or lack thereof) on the exam, what findings lead you to the conclusion the member is or is not substantially incapacitated?**

   Answer: The member has complained, on numerous occasions, of chest pain, for which he has been thoroughly evaluated and has been found not to have coronary artery disease to the extent that it could explain his chest pain on a cardiac basis. He has no symptoms of cardiovascular disease, such as exertional dyspnea, orthopnea, or paroxysmal nocturnal dyspnea. He has had a number of orthopedic injuries which have limited his physical activity and it is possible that, on that basis, he has not experienced exertional dyspnea. He does not have any physical examination findings of heart failure. His lower extremity edema, in my opinion, is due to amlodipine, which, at the dose of 10 mg, is known to commonly be associated with lower extremity edema, a benign condition. Therefore, it is my opinion that the member's subjective complaints do not lead to the conclusion that he is substantially incapacitated.

3. **If you find the member to be substantially incapacitated, is the incapacity permanent or temporary?**

   Answer: Not applicable.

4. **Please list the specific Job Duties and/or Physical Requirements of the Position the member is unable to perform <u>for each</u> substantially incapacitated body part / condition.**

   Answer: Not applicable.

5. **As of what date did the member's condition become "substantially incapacitating?"**

   Answer: Not applicable.

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

   Answer: It is my finding that the member did not exaggerate his complaints.

Thank you for referring this employee for evaluation. Should you have any further questions, please do not hesitate to contact this office.

<u>SOURCE OF FACTS AND DISCLOSURE:</u>

The source of all facts was the history given by the examinee and review of the previous examiner's medical reports. I personally interviewed the examinee, performed the physical examination, reviewed the history with the examinee, reviewed the medical records provided, dictated this report and it reflects my professional observations, conclusions

and recommendations. 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 the 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 declare that the following represents the physician time associated with this evaluation:

Face-to-face with examinee:	0.75 hour
Review of the records:	1.5 hours
Prep/review of report:	1.0. hour

Date of Report: [redacted]. Signed this [redacted] at [redacted] County.

Yours Sincerely,

Robert B. Weber, M.D., F.A.C.C.
Diplomate, American Board of Internal Medicine and
Subspecialty of Cardiovascular Disease

RBW/db

Attached: Record Review

REVIEW OF MEDICAL RECORDS:

[redacted]

DOB: [redacted]

Job Duty Statement: The patient works as officer for [redacted] *Highway Patrol. Under direction of a superior in the* [redacted] *Highway Patrol, to (1) patrol State highways enforcing laws relating to the operation of motor vehicles; or (2) provide law enforcement services to State employees, officials, and the public and provide for the safekeeping of State property; or (3) provide for the protection of the Governor, other constitutional officers, and members of the Legislature; or (4) perform special staff assignments; and to do other related work. Typical Tasks: Patrols the highways and unincorporated areas in an automobile or on a motorcycle using defensive driving tactics or is assigned to a fixed post duty; interprets and applies the provisions of the Vehicle Code and other complex laws, regulations, and court rulings when taking enforcement actions; operates a motor vehicle over extended hours, usually alone, while on patrol in all parts of the State under a variety of climatic, environmental, and traffic conditions, including pursuit driving under potentially hazardous circumstances; removes obstacles from the roadway to ensure the smooth flow of traffic; stops motorists for unsafe or illegal traffic actions or for vehicle equipment violations; issues all types of enforcement documents, including citations; conducts surveillance; makes a variety of in-custody arrests; pursues and physically subdues combative and belligerent persons, including armed felons; renders general assistance to members of the motoring public; administers field sobriety tests; takes charge at accident scenes or other emergencies; investigates traffic accidents; administers first aid; lifts and carries accident victims or prisoners in varying terrain and situations; testifies in court; monitors and operates the departmental mobile radio and emergency equipment while performing field enforcement duty; assists in miscellaneous activities such as traffic safety education programs and commercial vehicle inspections; reads a variety of reports and manuals; prepares a variety of reports and forms; maintains firearm proficiency; recovers evidence and provides for its safekeeping; interviews victims, witnesses, informants, and suspects for information to support criminal complaints; and controls crowds during disturbances and other assemblies. Physical Activities: Lifting and carrying objects weighing 10 to 25 lbs. Without assistance, lifting and carrying objects weighing 30 to 50 lbs. With assistance, lifting and carrying an individual resisting arrest (20-35 feet). Pulling/dragging a non-resistive/incapacitated person (160-200 lbs) 5-20 feet at an emergency situation or protest. Pulling/dragging an individual (160-200 lbs) resisting arrest 5-20 feet. Separate uncooperative persons (160-200 lbs) by pushing, pulling, using locks, grips, or holds, and physically restrain or subdue a resistive individual using reasonable force. Handcuff a suspect. Pulling/dragging heavy objects off the roadway (5-35 feet). Sitting in patrol car for an extended period of time during patrol or surveillance. Standing and directing traffic. Standing for extended periods at an accident/crime scene during stakeout, surveillance and crowd control, to provide security for various events, or to secure the perimeter. Stooping/squatting/kneeling to look for physical evidence under the seats or dash of a vehicle, in the trunk, and under the hood of a vehicle to look under a vehicle for evidence, suspects, defects, or violations; or to look under furniture for physical evidence at a crime/accident scene. Stooping/squatting/bending to set a flare pattern and ignite flares, to come at accident/crime scenes, to use a tape measure to measure skid marks or take measurements at an accident/crime scene. Frisk/pat down individuals for weapons.*

Walking continuously while on foot patrol for special assignments and to conduct searches. Walking around obstacles; over uneven ground; up hills/embankments, in loose dirt, gravel, mud, ice or snow. Walking to and from a violator's vehicle, or to keep an eye on a suspect. Distance walked in a day is ¼ to 1 mile. Run (5-100 yards) to get to an emergency or crime scene, to assist other officers, or to pursue a fleeing suspect. Climbing over a guardrail or median barrier (2-3 feet). Climb over chain link or wooden fences (5-7 feet) and over walls (4-7 feet). Climbing steep embankments, hills or gullies. Jumping across and/or over obstacles (e.g., guard rail) 2-4 feet and down from elevated (4 feet) surfaces (eg. fence). Fire 50-100 rounds with a handgun at a target during practice, firearms qualifications, or at a combat style shooting course. Fire a shotgun and rifle during practice, firearms qualifications, or on the job. Draw and hold a handgun, shotgun or rifle on a felony suspect until back-up arrives, or to cover an area of responsibility for extended time periods. Operate a computer keyboard in an office or in a patrol car (MDC) to enter/retrieve information and to complete reports or other documentation. Operate a radio, cellular phone, sirens and lights, and/or hand spotlight while driving a patrol vehicle. Drive on patrol under a variety of conditions and transport prisoners/suspects. Drive a patrol vehicle on open road at high speeds in response to a call or emergency or in pursuit of fleeing vehicles, under varied conditions. Drive a vehicle in a manner to slow down traffic (e.g., weaving back and forth). Monitor traffic to identify driver irregularities and vehicle defects. Examine vehicles for evidence (e.g., in the trunk, under the seat, under the hood), hazardous conditions (e.g., leaking fuel), or for safety or equipment violations. Inspect damage to vehicles or property. Visually estimate the speed of vehicles by checking the patrol vehicle speedometer and comparing it to the suspect vehicle. Read street signs, mailboxes, house numbers, license plates and the registration tag year from a vehicle and/or from a distance of up to 50 feet. Use a flashlight at night to read the license, registration and vehicle identification number, and to search areas for evidence, suspects or other individuals. Determine whether a person is under the influence of drugs or alcohol by using visual cues. Identify the model and color of vehicles from 100 feet away. Distinguish colors of traffic signals, signs and registrations tags. Recognize a person previously known based on a description (but wearing different clothing) from a distance of 30 to 100 feet. Hear a conversation over the sounds of machinery/traffic or other background noise (e.g., on the side of a road or freeway) while interviewing individuals or receiving information. Listen to radios and scanners, distinguish appropriate calls, and respond as needed. Listen for traffic approaching from behind during a vehicle stop or accident investigation. Listen to radar pitch to determine the speed of vehicles.

Disability Retirement Election Application. The patient had chest pain, high blood pressure and breathing difficulty. Disability occurred on [redacted] while typing reports at the office. Due to the injury, the patient is unable to perform the multiple duties that are required. The patient is not currently working in any capacity. Treating Physician: [redacted] MD.

Physical Requirements of Position/Occupational Title. No: Interacting or communicating with inmates, patients or clients; supervising staff; lifting or carrying of 26-50+ lbs; running, crawling, climbing or operating hazardous machinery. Infrequently: Interacting or communicating by

phone with public; lifting or carrying of 0-25 lbs; Kneeling, squatting, bending (neck), twisting (neck and waist), reaching (above and below shoulder), pushing and pulling, power grasping, handling (holding light grasping), fine fingering (pinching packing), walking on uneven ground, exposure to dust gas, fumes or chemicals and working at heights. Occasionally: Interacting/communicating with co-workers; standing, walking, bending (waist), exposure to excessive noise and exposure to extreme temperature. Frequently: Interacting/communicating face to face with public. Sitting and computer use (keyboard use). Constantly: Driving.

Physician's Report on Disability [redacted] MD dated [redacted]. The patient had work related injury. Diagnoses: 1. Chest pain. 2. Anxiety. The patient is currently substantially incapacitated from performance of the usual duties of the position for the current employer. The patient is unable to perform any of his job duties at this time. The incapacity is permanent.

[redacted] – Emergency Department Admit Note at [redacted] Hospital by [redacted] MD. The patient visits for sudden onset of intermittent left sided chest pain with radiation down the left arm that began while the patient was at work. Currently pain level 2-3/10 intermittently throughout the course of the day. The patient with surgical history of appendectomy and tonsillectomy. Denies smoking, drinking and drug use. Family history is significant for coronary artery disease and also high blood pressure. Vitals: Blood pressure: 160/93. Heart rate: 82. Respiratory rate: 20. Pulse oximetry: 98%. Temperature: 98.1. Emergency Department Course: The patient is having symptoms of chest pain with low risk factors for cardiac ischemia. The patient is currently completely chest pain free. The patient's case was discussed with Dr. [redacted] and the patient will be admitted to the hospital for repeat evaluation with cardiac stress testing to be performed and also serial cardiac markers to rule out acute coronary syndrome as the cause of the patient's pain. The patient is with no risk factors for pulmonary embolism at this time and the patient's pulse oximetry is normal. Administered Aspirin 325 mg. Diagnosis: Chest pain. The patient is admitted to telemetry observation in stable condition.

[redacted] – ECG at [redacted] Hospital interpreted by [redacted] MD.
Impression: Normal sinus rhythm. Nonspecific T wave abnormality. Prolonged QT interval or TU fusion. Consider myocardial disease electrolyte imbalance or drug effects. No previous ECGs available. Abnormal ECG.

[redacted] - X-ray of Chest at [redacted] Hospital interpreted by [redacted] MD/[redacted] MD.
Positive Findings: There is a small calcific density with a cortical margin seen adjacent to the tip of the left clavicle.
Impression: No acute process. Old left clavicle fracture.

[redacted] – Laboratory Report at [redacted] Hospital. Creatinine Kinase, Troponin tests are performed, and the values are found to be normal.

[redacted] ECG at [redacted] Hospital interpreted by [redacted] MD.
Impression: Sinus rhythm with premature atrial complexes. Otherwise normal ECG. When compared with ECG of 04/19/20. Premature atrial complexes are now present. Nonspecific T wave abnormality. No longer evident in inferior leads. Nonspecific T wave abnormality improved in anterior lateral leads.

[redacted] – Consultation at [redacted] Hospital by [redacted] MD. The patient was well until the previous day morning he noticed to have intermittent pain in the left side of chest with radiation down to left arm at work. As a Sheriff Officer he was noted to have lingering pain radiating to the back and left shoulder. Has some slight dyspnea. Then noted to have worsening of pain in the left side of chest with a lingering sensation in left hand with diaphoresis even though he stayed in the air conditioning rooms and subsequently he was brought to the hospital in the emergency room and admitted to [redacted] Hospital [redacted] for further evaluation and treatment. The patient had strain of the right hip in the past which was treated medically. Vitals: 99/71. Pulse: 67. Respirations: 20. Diagnosis: Atypical chest pains. There is family history of coronary artery disease and hypertension. There is no significant abnormal change of the laboratory studies. Will obtain nuclear medicine myocardial perfusion scan with treadmill.

[redacted] - Nuclear Isotope Stress Test at [redacted] Hospital interpreted by [redacted] MD.
Interpretation: The patient underwent a treadmill exercise study for myoview scan for evaluation of chest pain. The resting electrocardiogram shows normal sinus rhythm at a rate of 67 beats per minute. The patient exercised for a total of 9 minutes and achieved a heart rate of 176 beats per minutes which was 98% of the maximum predicted heart rate. There was gradual ST segment depression with a maximum ST segment depression minus 2 occurred at premature ventricular contractions induced by exercise.
Conclusion: 1. Abnormal treadmill exercise study with ST segment depression induced by exercise. 2. Rare premature ventricular contractions induced by exercise. 3. The patient was then sent to the radiology department for nuclear medicine myocardial perfusion scan.

[redacted] – Agreed Medical Evaluation ML-103-94 by [redacted] MD. Date of injury: [redacted] On [redacted] while at work the patient developed tightness in his chest along with numbness in left hand and dull pain in left upper arm. He was working at the [redacted] office. This occurred while at a fire station typing up a report. He said the discomfort occurred over a three-hour period. As he drove back to his office, he said he did not feel well. He told one of the sergeants, who told him that he looked pale and the sergeant took him to [redacted] Hospital. He was hospitalized for three days. He was told he had elevated blood pressure and a slightly enlarged left ventricle. His blood pressure was in the 150s to 160s systolic. He said he had a stress test at the hospital which was negative. He was discharged home and told to see his primary care physician. He was seen by Dr. [redacted] in [redacted] who placed him

on Simvastatin, but no anti-hypertensive medication was started as he declined taking any antihypertensive medication and said he would rather do it with diet, exercise and stress management. His blood pressure two weeks ago was 119 systolic taken by himself. When he started monitoring his own blood pressure after the hospitalization, it was in the 140s to 150s systolic. He also noted that his blood pressure at work with stress was 20 mm higher than at home. He said he has lost approximately 10 pounds since the hospitalization. He feels that work stress was the cause of his elevated blood pressure. He said that the [redacted] station is the busiest station in [redacted] for the past 15 years. He said the stress was from the volume of work and the revolving door of management and personnel. He said he saw a new sergeant and lieutenant almost every two months, and each time they would want to change procedures. He said 80% of the officers there would leave after two years and yet he stayed there for 14 years. He also described the danger of being a police officer, the fear of the next disaster and seeing injured and dead bodies. He transferred in December [redacted] to the [redacted] office, which he said is much less stressful. The volume of work is less, and the management is stable. He gained 30 pounds after a crush injury when he was hit by a car into a wall in [redacted]. He developed a hernia in [redacted] and also had decreased ability to exercise for nine months and gained approximately 10-15 pounds. He said these injuries are the major reason he had inability to exercise and resulted in weight gain. In terms of family history, his mother developed hypertension at age 55-60 and his father developed hypertension at approximately 60. He has two maternal uncles who developed hypertension in their 70s. He was out of work for three months due to hypertension. His prior Workers' Compensation claims include right hip eye injuries back which resulted in 19% disability granted in December of [redacted] and left inguinal hernia repair. The patient is with a surgical history of tonsillectomy, deviated septum and left inguinal hernia. Social alcohol consumption. Current Meds: Baby Aspirin and Simvastatin. Review of systems significant for heartburn in the mornings from January through July of [redacted]. None since which he related to work stress. Vitals: Height: [redacted]". Weight: [redacted] lbs. Blood pressure: 160/100 in the right arm for the first time. 156/100 in the right arm for the second time. Pulse rate: 70. Respiratory rate: 16. Oxygen Saturation: 98%. Electrocardiogram revealed sinus rhythm. There were no abnormalities noted. Spirometry was within normal limits. Diagnosis: Hypertension. Causation: Stress at work caused hypertension. Impairment Rating: The patient has not reached maximal medical improvement at the time of this evaluation. He has significantly elevated blood pressure for which he has not been given any medical treatment. Therefore, he should be treated for his elevated blood pressure. The patient missed three months of work due to his hypertension, and that period of time should be reimbursed on an industrial basis. Apportionment: His hypertension should be considered 90% industrially related due to work-related stress and weight gain due to decreased ability to exercise secondary to his industrial hernia and industrially related back injury and 10% should be considered non-industrially related secondary to his preexisting obesity and to his family history of hypertension. Work Restrictions: He has no work restrictions and is fully capable of performing his usual and customary work as a [redacted] officer. Future Medical Care: The medical treatment for his hypertension should be paid for on an industrial basis. He will require anti-hypertensive medication, and would like to see the

patient back in approximately nine months after he has been treated for his hypertension to see if he has reached maximal medical improvement at that time and issue final report at that time.

[redacted] - Transthoracic Echocardiogram at [redacted] Medical Center interpreted by [redacted]
Conclusion: Left ventricular size was normal. There were no left ventricular regional wall motion abnormalities. Left ventricular thickness was at upper limits of normal, left ventricular ejection fraction was calculated to be 64%. A low E/E ratio (less than 8) usually indicates normal LAP (less than 10 mmHg). Right ventricular systolic function was normal. Normal inferior vena cava size 15 mm Hg and respiratory excusion consistent with normal right atrial pressure.

[redacted] - Agreed Medical Evaluation ML 102-94 by [redacted] MD. Date of injury: [redacted] Examiner last saw the patient on [redacted] The patient has been followed by Dr. [redacted] He was examined by her approximately three hours after he saw this examiner and apparently his blood pressure was down to 120 systolic. He said that talking to this examiner about the [redacted] station made him very anxious and caused his blood pressure to become elevated. He had approximately seven follow-up visits with Dr. [redacted] and his blood pressure has been between 120 and 135 systolic and in the mid-80s diastolic. He was not started on any antihypertensive medication. He has exercised more. Changed his diet avoiding red meat and eating more vegetables. He has lost between 7 and 10 pounds. He has not missed any time from work due to hypertension. He has continued doing his usual and customary duties at the [redacted] office. Vitals: Height: [redacted]". Weight: [redacted] lbs. Blood pressure: 122/92 in right arm for the first time; 130/90 in right arm for the second time; 134/84 in right arm for the third time; 120/90 in left arm at first time and 130/80 in left arm for second time. Respiratory rate: 16. Pulse rate: 60. Oxygen saturation: 98%. There were laboratory tests from Quest Diagnostics done on [redacted]. Urine for microalbumin was 10 mcg/mg creatinine with normal being less than 30. Cholesterol was 215. Glucose 106. BUN 12. Creatinine 1.08. Sodium 138. Potassium 4.6, Chloride 102. Calcium 9.4. Total protein 7.0. Albumin 4.7. Globulin 2.3. Total bilirubin 0.6. Alkaline phosphatase: 43. AST: 26. Hemoglobin A1C: 5.5. Uric acid 6.5. Direct bilirubin 0.1 and ALT 46. Urinalysis was normal CBC revealed hematocrit was 41.0. Hemoglobin 14.4. White blood cell count 5400. Platelet count 213000 with 63 polys. 26 lymphs. 8 monos and 4 eosinophils. Diagnosis: Hypertension. Causation: [redacted]. Impairment Rating: Reached MMI. 5% whole person impairment. There are no changes to apportionment or work restrictions. Apportionment: As far as medical treatment is concerned his blood pressure should continue to be monitored and if he remains in stage I hypertension, the medical treatment for hypertension should be paid for on an industrial basis. All medications office visits and any complications related to his hypertension should be paid on an industrial basis.

[redacted] – Sleep Study at Preferred Sleep Solutions. Sleep study was performed. (Poor Quality Image)

[redacted] - Patient Encounter Note by [redacted] PA-C. The patient is having lower back pain secondary to degenerative disc disease. Got physical therapy today. He has 3 more sessions of acupuncture therapy, but he would like to continue to go as this is what helps control his pain the best, even over pain medication. The patient saw state compensation doctor who determined his injuries are permanent and stationary with permanent disability estimated at 19%. He is trying to lose more weight which he knows will help his back pain. He is off Norco now and on Aleve 220 mg. Pain level today is 1.5/10. The patient is having cervicalgia due to cervical spinal stenosis. The patient is able to turn his neck side to side without pain. Pain level today is 1.5/10. The patient is having osteonecrosis of right hip. Pain is tolerable. No longer requires Norco and Aleve. Completed physical therapy. Vitals: Height: [redacted]0. Weight: [redacted] lbs. Blood pressure: 124/78. Pulse: 80. Temperature: 98.6. Body mass index: [redacted] kg/m2. Diagnoses: 1. Spinal stenosis, cervical region. 2. Osteonecrosis, unspecified. 3. Other intervertebral disc degeneration. 4. Low back pain. Obtain authorization for 12 more sessions of acupuncture. Full duty.

[redacted] – Utilization Review Determination by [redacted] MD. Requested 12 visits of acupuncture therapy for low back is denied.

[redacted] - Progress Note by [redacted] MD. The patient is here today for FAA second class medical certificate-IF. Vitals: Temperature: 98.6. Heart rate: 78. Blood pressure: 120/70. Weight: [redacted] lbs. Body mass index: [redacted] kg/m2. Height: [redacted] inches. Diagnosis: Encounter for general adult medical examination without abnormal findings.

[redacted] - Ultrasound of the Endovenous Occlusion Duplex Assessment by [redacted] MD. Comments: 1. Positive bilateral greater saphenous vein reflux. 2. Negative bilateral small saphenous vein reflux. 3. No deep venous thrombosis.

[redacted] Progress Note by [redacted] MD. The patient is having obstructive sleep apnea. Needs to get clearance for his FAA medical. He uses CPAP every night 97-98%. Needs FAA special insurance. Having varicose veins with complication and presents to review vein mapping. Currently taking Hydrochlorothiazide 12.5 mg. The patient presents to follow up on his blood pressure. Currently taking Losartan 100 mg and Hydrochlorothiazide 12.5 mg. Vitals: Temperature: 98.6. Heart rate: 80. Blood pressure: 120/80. Weight: [redacted] lbs. Body mass index: [redacted] kg/m2. Respiration rate: 14. Height: 172 cm. Diagnoses: 1. Obstructive sleep apnea. 2. Varicose veins of bilateral lower extremities with other complications. 3. Essential primary hypertension. Advised to continue wearing CPAP every night. Advised to elevate legs for 30 minutes twice a day and wear compression stockings. Continue Hydrochlorothiazide 12.5 mg and Losartan Potassium 100 mg. Recommended low sodium intake less than 3 grams per day. Advise to exercise for 30-45 minutes 3-4 x/week.

[redacted] – Emergency Department Physician Note at [redacted] Regional Hospital by [redacted] MD. The patient with history of LVH presents with chest pain. Has chest pain intermittently since the previous day. The first episode of chest pain occurred the previous day

and resolved on its own. The same day morning the patient went to work and experienced another episode of pressure like left sided chest pain radiating to left arm and left jaw. The patient with sudden onset of mild left chest pressure radiating to left arm and left jaw. Current alcohol consumption. Vitals: Temperature: 98.7. Heart rate: 97. Respiration rate: 16. Blood pressure: 137/84. SpO2: 98%. Weight: 118 kg. Diagnosis: Unstable angina. Administered Morphine injection 3 mg. Prescribed Nitroglycerin 2% transdermal ointment. The patient is admitted to the hospital for further evaluation and care.

[redacted] – ECG at [redacted] Regional Hospital interpreted by [redacted] MD.
Impression: ECG shows 80 beats per minute. Normal sinus with sinus arrhythmia with no ectopics. Conduction normal. ST segments non-specific. T waves, nonspecific. Axis normal. Abnormal ECG.

[redacted] - X-ray of Chest at [redacted] Regional Hospital interpreted by [redacted] MD.
Impression: Heart size is normal, and the lungs are clear.

[redacted] – Admission History & Physical Report at [redacted] Regional Hospital by [redacted] MD. The patient with history of LVH presents with chest pain while doing paperwork at work. Had intermittent chest pain since the previous day. First episodes of chest pain occurred the previous day and resolved on its own. This morning the patient got to work and experienced another episode of pressure like left sided chest pain radiating to left arm and left jaw. The patient was brought to San Antonio Regional Hospital emergency room for further evaluation and management. Vitals: Temperature: 98.7. Heart rate: 97. Respiration rate: 16. Blood pressure: 137/84. SpO2: 98%. Weight: [redacted] kg. Diagnoses: 1. Chest pain, unstable angina. 2. Hypertension. 3. Hyperlipidemia. 4. Diabetes mellitus 2, uncontrolled with hyperglycemia. Admit to telemetry. Recommended IV fluids and repeat troponin levels. Follow up cardio consult and A1C. Increase Statin. Continue Glucose evaluation and management. Lovenox, PPI as needed.

[redacted] – Consultation at [redacted] Regional Hospital by [redacted] MD. The patient is having stress at work with the new management. In the last few days, he has been feeling uptight. This morning, he was at his job typing something in the computer. He started feeling heaviness in chest, fullness in throat and left arm discomfort. He checked his blood pressure and it was high at 190s. Hence the patient came to [redacted] Regional Hospital. Given Nitroglycerin and then chest comfort got better. A similar discomfort in [redacted] admitted to [redacted] Hospital. Workup was unremarkable. He has been having hypertension. Told to have left ventricular hypertrophy. About 3 years ago he went on a diet, some exercise and stopped all his blood pressure medication. As far as activity is concerned, he cannot jog or run. He just walks the dog and plays golf. No regular cardiac exercise. Previous medical history: He had hypertension before as well as left ventricular hypertrophy but not taking medication. He says it came down. History of obstructive sleep apnea. Vitals: BP: 126-140/83. Heart rate: 56. Respirations: 18. Oxygen saturation: 98%. Diagnoses: 1. Chest discomfort, rule out acute coronary syndrome. 2. Left ventricular hypertrophy. 3. History of hypertension in the past. Now

also he is hypertensive. 4. Overweight, obesity. 5. Obstructive sleep apnea. 6. Likely prediabetic status. Recommended echocardiogram and exercise stress test. The patient needs diet control. Given diabetes education. Check serum lipid panel. Prescribed Amlodipine 5 mg. The patient is on Aspirin and Nitro-bid transdermal ointment. DVT prophylaxis dose Lovenox.

[redacted] – Laboratory Report at [redacted] Regional Hospital. RBC (L) 3.99. Hgb (L) 13.3. MCH (H) 33.4. Monocytes% (H) 9. Basophils (H) 0.1. Glucose level (H) 147. Albumin level (L) 3.3. Cholesterol (H) 255. Triglyceride (H) 159.

[redacted] - Procedure Report at [redacted] Regional Hospital by [redacted] MD. Procedure Performed: 1. Left heart catheterization. 2. Selective coronary angiography. 3. Left ventriculography. 4. Moderate sedation for 20 minutes. 5. Cardiac fluoroscopy.
Findings: 1. Left main artery: No significant obstruction. 2. Left anterior descending artery: No significant obstruction. 3. Left circumflex artery: No significant obstruction. 4. Right coronary artery: No significant obstruction. 5. LV gram shows ejection fraction of 55%. 6. Left ventricular end diastolic pressure is 12 mmHg.
Impression: 1. No evidence of obstructive atherosclerotic heart disease. 2. Normal left ventricular systolic function. Recommended to monitor access site. IV fluid hydration.

[redacted] - Echocardiogram at 15:06 at [redacted] Regional Hospital interpreted by Muthusamy Muthiah, MD.
Final Impression: This study shows normal left ventricular size and systolic function. Mild left ventricular hypertrophy. Estimated ejection fraction 50% to 55%. Consider left ventricular relaxation abnormality. No underlying valve abnormality. No pericardial effusion. (Partial Document).

[redacted] Echocardiogram at 15:14 at [redacted] [redacted] Hospital interpreted by [redacted] MD.
Final Impression: His functional capacity is fair. Adequate stress of heart and test is positive for underlying coronary ischemia. After that, examiner recommended him to have cardiac catheterization. The patient understood and agreed. Will proceed with cardiac catheterization.

[redacted] - Progress Note at [redacted] Regional Hospital by [redacted] MD. The patient denies any chest discomfort or any shortness of breathing. Vitals: Blood pressure: 121 to 146 over 81. Heart rate: 62-91. Respirations: 14. Oxygen saturation: 97%. Diagnoses: 1. Chest discomfort. His workup is normal. 2. Left ventricular hypertrophy. 3. Hypertensive heart disease. 4. Hyperlipidemia. 5. Obesity. 6. Obstructive sleep apnea. Discussed lifestyle modification. Prescribed Amlodipine 5 mg and Atorvastatin 10 mg. Advised stress relaxation measures.

[redacted] - Progress Note by [redacted] MD. The patient remains on Aux unit status post cardiac cath today. Inpatient Meds: Amlodipine, Aspirin, Ativan, Atorvastatin, Atropine, Insulin sliding scale, Morphine injection, Narcan, Nitroglycerin sublingual tab, normal saline, Tylenol

and Zofran injection. Vitals: Temperature: 98.1. Maximum: 98. Minimum: 97.3. Heart rate: 76. Respiration rate: 16. Blood pressure: 137/91. SpO2: 99%. Weight: [redacted]kg. Exam: R wrist access site dressed. Clean, dry and intact. Diagnoses: 1. Chest pain, status post cardiac cath [redacted] 2. Hypertension. 3. Hyperlipidemia. 4. Diabetes mellitus 2, uncontrolled with hyperglycemia; A1C 8.8 on [redacted]. Resume home meds. Increase Statin. Continue current medical management. Monitor radial access site. Anticipate discharge to home when clear per cardio. Continue glucose evaluation and management. Lovenox PPI as needed.

[redacted] – Discharge Summary at [redacted] Regional Hospital by [redacted] MD. Admission Diagnosis: Unstable angina. Discharge Diagnoses: 1. Chest pain, status post cardiac cath [redacted] 2. Hypertension. 3. Diabetes mellitus, uncontrolled with hyperglycemia; A1C 5.8 on [redacted] Lovenox PPI as needed. Resume meds. Hospital Course: The patient is admitted to telemetry. Cardiac consult requested. Underwent cardiac cath on [redacted]. The patient's symptoms slowly improved over the course of his stay. Vitals: Temperature: 98.1. Minimum: 97.3. Maximum: 98.6. Heart rate: 76. Respiration rate: 16. Blood pressure: 137/91. SpO2: 99%. Weight: [redacted] kg. Exam: Right wrist access site dressed. Clean, dry and intact. Prescribed Amlodipine 5 mg and Atorvastatin 40 mg. Discharged in stable condition.

[redacted] - Progress Note by [redacted], MD. The patient was given Amlodipine 5 mg for hypertension when he was at San Antonio Regional Hospital in the End of February. He spent 3 days in the hospital getting a full cardiac workup. They were constantly giving him Nitroglycerin which didn't work. The patient can feel how high his blood pressure is. The patient is not sleeping. The patient is having anxiety. About 2 months ago he got a new captain to his job. As soon as he got there, he started firing employees. This captain is notorious for moving around and firing large numbers of staff. The patient was working on his paperwork and all of sudden started feeling his heart rate racing and a pounding in his ears and then the next thing he was on his way to the hospital. The patient has not been getting enough sleep lately. Since he has been stressed out with his new captain and his new approach with the employees. He is unable to get to sleep easily and he is unable to stay asleep for very long. This is making it hard for him to concentrate at work and do his job properly. Vitals: Temperature: 97.6. Heart rate: 90. Blood pressure: 170/82. Weight: [redacted] lbs. Body mass index: [redacted]kg/m2. Height: [redacted] inches. BECK questionnaire score is 3. Diagnoses: 1. Essential primary hypertension. 2. Anxiety. 3. Insomnia, unspecified type. Prescribed Xanax 0.5 mg. Refill Losartan Potassium 25 mg and Hydrochlorothiazide 12.5 mg. Continue Amlodipine Besylate 5 mg. Avoid stress triggers. Reduce salt intake. Advised to stay active and exercise regularly. Recommended to try some breathing techniques to help him relax and drink plenty of water. Sleep in dark and quite room. Continue to monitor.

[redacted] – Consult by [redacted], MD. The patient is not taking Amlodipine. Taking Losartan 25 mg and Hydrochlorothiazide 12.5 mg. Also brought in blood pressure log. Systolic lowest is 140 and the highest being 189. Diastolic lowest is 71 and the highest is 95. The patient states in his blood pressure log when he was mopping and vacuuming the floor he had chest pain on

[redacted]. The patient currently has chest pain feeling like bruise on chest that happened 3 days ago and still has pain. It is not a sharp pain just feels like he got hit in the chest. Had chest pain 7 times in his blood pressure log. 3 were work induced, once when starting meds and once while doing house chores. Pain sometimes goes down his left arm. He feels tense in his throat on [redacted] and was taken to the hospital the same day. They ran a stress test. Stopped the test to do an angiogram that had no findings. Pt would like to retire in 2 months and has one year and 2 months left. The patient is having pain on the ball of left foot. Feels as if there is a watery blister. The patient can feel his feet swelling. Current pain level 2/10. Numbness from second toe to his 4th toe. His feet do swell normally throughout the day, but it became more prominent in left foot. Current Meds: Losartan Potassium, Hydrochlorothiazide, Xanax, Vitamin-D, Aspirin and Amlodipine. Vitals: Temperature: 97.8. Heart rate: 72. Blood pressure: 140/84. Weight: [redacted]lbs. Body mass index: [redacted]kg/m2. Height: [redacted] inches. Exam: Foot: Swollen. Red to touch. Ball of foot is green and yellow. Diagnoses: 1. Essential hypertension. 2. Other chest pain. 3. Left foot pain. Stop Losartan Potassium 25 mg. Prescribed Losartan Potassium 50 mg. Continue Hydrochlorothiazide 12.5 mg. Advised to soak left foot in Epsom salt and elevate foot. Advised to continue monitoring left foot.

[redacted] - Progress Note by [redacted], MD. The patient presents to follow up for his blood pressure. The patient is taking Losartan 100 mg, Hydrochlorothiazide 12.5 mg and Amlodipine 5 mg. Having couple of rough days and states his blood pressure has been high. The patient is logging his blood pressure and it has been high. Having chest pain that has been going away. Chest pain feels like someone punched him. The patient has shortness of breath when he is pissed off. At work the patient was typing and felt chest pain, tightness, and shortness of breath. Vitals: Temperature: 98.7. Heart rate: 76. Blood pressure: 160/90. Weight: [redacted] lbs. Body mass index: [redacted] kg/m2. Height: [redacted] inches. Diagnosis: Essential Hypertension. Increase Amlodipine Besylate 10 mg. Continue Losartan Potassium 50 mg and Hydrochlorothiazide 12.5 mg. Prescribed Metoprolol Succinate Extended release 24 hours 25 mg. Blood pressure diary reviewed with the patient. Recommended low sodium diet and less than 3 grams per day. Encouraged weight loss. Off duty until [redacted].

[redacted] – Office Visit by [redacted], NP. The patient is having atypical chest pain. He started with the chest back in February [redacted] while he was sitting down typing on a computer at work. This has been an ongoing situation since then. He is having chest pain now. It feels like a dull pain in his left chest like if someone punched him in the chest. The chest pain is a constant thing. Aggravating factors include being at work and thinking about work. Relieving factors include taking his dog for a walk. He wants to submit the paperwork for his retirement. For hypertension, the patient is currently taking Losartan 50 mg, Metoprolol 25 and Hydrochlorothiazide 12.5 mg. He is unsure if he is taking Amlodipine 10 mg. He was unaware that he was supposed to take Amlodipine 10 mg and Metoprolol. He will go home and check if his Losartan was supposed to be 50 mg or 100 mg. The patient seems very unsure of what medication he is to be taking. For anxiety, the patient has the Xanax 0.5 mg but he has not touched the medication since it was given to him. When he starts to feel anxious that is when he can feel

his blood pressure shoot up. There has been a change in management at his job and since then there has been a significant increase in stress. The patient constantly thinks about his job. The patient is requesting disability form papers to be filled out. Vitals: Temperature: 97.6. Heart rate: 76. Blood pressure: 166/98. Height: 68 inches. Diagnoses: 1. Atypical chest pain. 2. Essential (primary) hypertension. 3. Anxiety. Prescribed Xanax 0.5 mg. Continue to monitor chest pain. Start taking blood pressure meds. Advised to keep track of blood pressure and bring blood pressure log back to re-evaluate. Will continue to monitor. Advised to try some yoga breathing.

RBW/rpc/au
[redacted]

June 23, 2022

TO: Ricki Contreras, Manager
Disability Retirement Services

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

FOR: July 6, 2022, Board of Retirement Meeting

SUBJECT: APPLICATION TO LACERA's PANEL OF EXAMINING PHYSICIANS
PAUL J. GRODAN, M.D. – INTERNAL MEDICINE

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 Paul J. Grodan, M.D. be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

The Disability Retirement Services Division engaged Garland & Associates Medical Legal Public Relations & Marketing to discuss potential candidates for the LACERA Panel of Examining Physicians. Garland & Associates purpose is to develop referrals for treatment cases, medical legal evaluations, including, impairment for Workers' Compensation, fitness for duty evaluations, and independent medical examinations, and expert witness testimony. Their network includes expertly trained and highly skilled physicians within a variety of specialties.

Paul J. Grodan, M.D., is Board Certified in Internal Medicine with a subspecialty in Cardiology. He received his medical degree from McGill University, School of Medicine in 1973 and completed his residency at the Montreal General Hospital in Montreal Canada. Dr. Grodan has 41 years of experience performing medical legal evaluations for both public and private organizations. He currently serves as an Associate Clinical Professor of Medicine at the University of Southern California School of Medicine. Dr. Grodan is a certified by the State of California as Qualified Medical Evaluator.

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. Staff will also provide an overview of the Quality Control Questionnaire process and procedures.

On June 8, 2022, Board Medical Advisor Glenn Ehresmann, M.D., reviewed the application and medical credentials and indicated he agrees with submitting the Application of Paul J. Grodan, M.D., to the Board of Retirement for consideration.

IT IS THEREFORE RECOMMENDED THAT the Application of Paul J. Grodan, 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 12/27/2021
Physician Name: PAUL J GRODAN, M.D.	Group Name: Click or tap here to enter text.
Primary Address: 4940 VAN NUYS BLVD , SUITE 202, SHERMAN OAKS, CA. 91403	
Primary Contact: SILVA BUCHHARDT	Title: PRACTICE MANAGER
Telephone: 310-854-0100 Fax: 818 -810-6875	Email: [redacted]@GMAIL.COM
Secondary Address: SEE ATTACHED FOR TWO SATELITE LOCATIONS FOR QME'S	
Telephone: 310-854-0100 Fax: 818-810-6875	Email: [redacted]@GMAIL.COM

PHYSICIAN BACKGROUND	
Field of Specialty: INTERNAL MEDICINE Board Certification ☒Yes ☐No	Subspecialty: CARDIOLOGY Board Certification ☐Yes ☒ No
License # **G30279** Expiration Date: **12/31/2022**	
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	21
IME	8
QME	18
Workers' Compensation Evaluations	35
Disability Evaluations	41

Current Practice	Time Spent (%)
Treatment	35
Evaluations	60
Research	--
Teaching	5
	100 %

Med-Legal Reports			

Performing Medical Evaluations for Public Organizations ☒Yes ☐No

Performing Medical Evaluations for Private Organizations ☒Yes ☐No

Please Names of Organizations: COUNTY OF LA, CITY OF LA CO. SEDGWICK, AIMS,

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 WORKING DAYS - FEE- $503.75

Cancelled Exams that do not adhere to your stated policy: Fee: $ Click or tap here to enter text.

Cancelled Hearings that do not adhere to your stated policy: Fee: $ Click or tap here to enter text.

Name of person completing this form:

Print Name: PAUL J. GRUDAN	Title: M.D
Physician Signature:	Date 12-27-2021

You may attach additional pages if necessary.

Revised: 12/8/21

PAUL J. GRODAN, M.D., FAHA

LOMATE AMERICAN BOARD OF INTERNAL MEDICINE
INTERNAL MEDICINE
CARDIOVASCULAR DISEASES

CURRICULUM VITAE

NAME: PAUL J GRODAN, M.D.

ADDRESS: 4940 Van Nuys Blvd, Suite 202
Sherman Oaks, California 91403
Tel. (310) 854-0100 Fax (818) 810-6875

DATE OF BIRTH: [redacted]

LICENSURE:

Licentiate of The Medical Council of Canada	1974	#37.205
Quebec College of Physicians & Surgeons	1974	#74-464
California Board of Medical Examiners	1975	#G-30279

EDUCATION

COLLEGE: McGill University
Montreal, Canada
B.Sc. Degree 1969
Honors in Microbiology & Immunology

MEDICAL SCHOOL: McGill University
School of Medicine
Montreal, Canada
M.D.C.M. 1973

AWARDS

MEDICAL SCHOOL: University Scholar 1969-1973
Frederick Smith Memorial Scholar
Primary Prize (First in Graduating Class)
Joseph Morley Drake Prize in Pathology

MEDICAL TRAINING

INTERNAL MEDICINE: Montreal General Hospital 1973-1974
Montreal, Canada
Straight internship in internal medicine

Montreal General Hospital 1974-1975
Montreal, Canada
Residency in internal medicine

CARDIOLOGY:

Harbor General Hospital — 1975-1977
Torrance, California
Clinical Fellow in Cardiology

Cedars-Sinai Medical Center — 1977-1978
Los Angeles, California
Clinical & Research Fellow in Cardiology

PROFESSIONAL BACKGROUND

BOARD CERTIFICATION:

National Board of Medical Examiners — 1974 — #135400
American Board of Internal Medicine, Certified — 1974 — #G3074

HOSPITAL AFFILIATIONS:

Cedars-Sinai Medical Center

UNIVERSITY APPOINTMENT:

Assistant Clinical Professor of Internal Medicine U.C.L.A.

TITLE:

Cardiologist

MEDICAL/LEGAL:

Social Security Administration – Medical Advisor
Qualified Medical Examiner

PROFESSIONAL SOCIETIES

MEMBER:

American College of Physicians
American College of Cardiology – Associate Fellow
Fellow of American Heart Association – F.A.H.A.
Los Angeles County Medical Association
California Medical Association

PROFESSIONAL ACTIVITIES

Los Angeles Board Member of American Heart Association Western States Affiliate — 2010 –
Los Angeles Heart & Stroke Ball Executive Leadership Team — 2014

CSMC TEACHING ACTIVITIES

Department of Cardiology EKG Course for UCLA School of Medicine Students (since approximately 1980)

PUBLICATIONS & RESEARCH

None in the last 10 years

PAUL J. GRODAN, M.D., FAHA

A PROFESSIONAL CORPORATION
DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE
CARDIOVASCULAR DISEASES
QUALIFIED MEDICAL EXAMINER
CONSULTS
TREATING PHYSICIAN
TAX ID: 95-3527320

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RANCHO CUCAMONGA, CA 91730
PHONE: (909) 629-6667

SANTA CLARITA OFFICE
28212 KELLY JOHNSON PKWY, SUITE 235
VALENCIA, CA 91355
PHONE: (310) 854-0100

SAMPLE REPORT #1

PANEL QUALIFIED MEDICAL EVALUATION

Gentlemen:

I was asked to evaluate . He was previously evaluated on July 30, [redacted] for his initial claim. My report was issued at that time reflecting the Panel QME evaluation, then supplemental reports dated [redacted] and [redacted]

Evidently his claim was settled and he filed Petition to Reopen for new and further disability. I received limited records for review. I have reviewed my prior records including the three reports. The attestation for the new submission was for 19 pages. The total review does not exceed 50 pages. Following history was obtained currently.

EDUCATIONAL, OCCUPATIONAL AND MEDICAL HISTORY:

[redacted] worked as an [redacted] officer since he was hired in [redacted]. He was evaluated previously on [redacted] at my office and he last worked on [redacted].

His occupational history was outlined in my [redacted] report and that will not be repeated at this time.

[redacted] last worked on [redacted] and retired as of [redacted]. He received medical retirement. His internist is Dr. [redacted].

He noted that he settled his claim on [redacted] but reopened the claim because of elevated blood pressure, having palpitations, and skipping of heartbeats. He was seen by cardiologist Dr. [redacted]. He noted that he was seen earlier in [redacted]. His blood pressure fluctuated. He reported chest pain, shortness of breath at least once or twice a week. He has not worked since he retired. He noted that retirement was due to high blood pressure. He noted that he was placed off work as of [redacted] through [redacted] due to his shoulder. Orthopedic not internal medical based disability. He never returned to work. He had left shoulder surgery on [redacted] had arthroscopy by Dr. [redacted] and the condition improved. [redacted] physical therapy.

He is taking olmesartan 40 mg daily for blood pressure since last year. He noted that he had almost weekly telephone encounters with his physician. He noted blood pressure is checked at home. However, according to him it is still high. He has no pain only headache. At times, side of the head hurts. He takes Excedrin which doesn't help. If he takes his blood pressure medication usually it helps.

The exercise consist of walking, some jogging, goes to the gym doing light weights sporadically.

[redacted] noted having psoriasis mostly on his scalp since using Cosentyx to treat psoriasis; before was more extensive and he also has psoriatic arthritis. He noted that having psoriasis makes it more difficult for him to go the gym considering his appearance.

Sleep is interrupted, gets 3 hours at times will fall back to sleep. He will try to nap during the day. When asked what awakes him up response was "just wake up", he could not identify specific cause except occasionally he feels heart racing.

Appetite is okay. He has one meal daily. Energy level however is poor. Lately he is fatigued.

He denied family history of hypertension, has a son 31 who is healthy.

Since he left work stress level has improved. He noted that he just completed remodel of his home which took 5 months by a contractor.

On the day of this evaluation he was feeling tired; his sleep last night was only about 3½-hours. He noted indigestion, heartburn, acid reflux. He does not drink coffee. Alcohol only socially once or twice a month. He doesn't smoke. He avoids spicy foods. Occasionally he has fried foods. He had endoscopy in [redacted] which was normal. Colonoscopy was also normal.

[redacted] drinks lots of water. He indicated constipation and diarrhea on and off on a weekly basis. He described constipation as no bowel movement for 3 or 4 days, it is occasional. He has some loose bowel movements after constipation.

He reported stiffness due to psoriatic arthritis. He noted that his physician considered changing from Cosentyx to something else.

After [redacted] his workload was heavy, he had to deal with citizen problems, there was increased stress due to "situation". He found it very stressful dealing with the citizens.

Chief complaint on health questionnaire was left blank.

PAST HISTORY:

He noted knee surgery, shoulder surgery, no other admissions.

FAMILY HISTORY:

Father deceased at 83 of emphysema. Mother at 83 had diabetes and possibly stroke.

SOCIAL HISTORY:

is single, never married but lived common law 11 years. He noted son 31 in good health. He has a brother 66 and sister 57 in good health.

Current medications are only Cosentyx, pantoprazole as needed not daily, famotidine as needed, olmesartan 40 mg daily, and Flomax 0.4 mg daily. Denied allergies.

REVIEW OF SYSTEMS:

He noted sleep not regular 3 hours nightly and snoring. On one questionnaire he indicated frequent headaches, possibly migraines every 2 days associated with increased blood pressure. He noted need for eyeglasses, decreased hearing acuity, stuffy nose, sneezing, high blood pressure, palpitations, skipping of heartbeats, exertional dyspnea, and diarrhea and constipation.

On the second questionnaire noted sex life is satisfactory, noted the issue with psoriasis with rash, need for eyeglasses, headaches, sneezing, neck stiffness, thyroid problem, enlarged gland, and noted chest pain, high blood pressure, swelling of extremities, peptic ulcer, painful bowel movements, hemorrhoids, diarrhea, indigestion, heartburn, cramping. Nocturia 0-3 times nightly, not increased daily frequency and noted transurethral removal of kidney stone. He noted some muscle weakness.

PHYSICAL EXAMINATION:

is a well-nourished African-American male in no distress.

VITAL SIGNS:	HEIGHT:	[redacted]
	WEIGHT:	[redacted] lbs.
	BP:	140/100
	PULSE:	60, regular
	RESP:	18
	TEMP:	Afebrile

HEAD: Not examined due to Covid-19 and masking.

EYES: Not examined due to Covid-19 and masking.

ENT: Not examined due to Covid-19 and masking.

NECK: Supple, no nodes, no thyroid palpable, no bruit.

CHEST: Clear, no rales, rhonchi or wheezing.

HEART: No murmurs, gallops or clicks, regular rhythm.

ABDOMEN: Flat, no organomegaly, masses, tenderness, bruits or hernias.

EXTREMITIES: Pulses full, no edema, no clubbing, no cyanosis, no varicosities, no deformity, no atrophy.

NEUROLOGICAL: Deep tendon reflexes 0-1+ symmetrically, no focal findings, no deficits, no lateralizing findings.

SKIN: Tattoo left arm otherwise no lesions.

LABORATORY INVESTIGATIONS:

Complete blood count, platelet count, and sedimentation rate were normal.

Urinalysis revealed trace protein and few hyaline cast otherwise negative.

Serum iron, T4, magnesium, and uric acid were in normal range. Chemistry panel was entirely normal with a borderline glucose at 101.

Lipid panel revealed cholesterol elevated slightly at 207, HDL 65, triglycerides 92, LDL 122 elevated, non-HDL cholesterol elevated at 142 and favorable cholesterol/HDL risk ratio at 3.2. The lipoprotein(a) level was 34 which is within the optimal risk for cardiac event.

Glycohemoglobin A1c was 5.6% ruling out diabetes.

Resting EKG revealed sinus rhythm rate of 64 with normal intervals and nonspecific ST-T changes. There was slight ST segment elevation consistent with repolarization variant.

Echocardiogram revealed normal contractility, concentric hypertrophy with posterior wall at 1.3 cm, septum 1.5 cm, dilated left atrium at 4.6 cm, borderline dilatation of right ventricle at 2.8 cm. Ejection fraction 70%, he had trace aortic,

mild pulmonic and mitral, as well as tricuspid insufficiency, calculated right ventricular systolic pressure is 26 mmHg. **Full report is enclosed.**

completed the Epworth Sleepiness Scale questionnaire with a score of 12 indicating moderate chance of dozing or sleeping while sitting inactive in public place, passenger in a car for an hour without a break, and laying down to rest in the afternoon. High chance sitting and reading and watching television.

He also completed the 6-page ADL questionnaire noting that all issues are due to orthopedic injury not internal medical. He has no problem with self-care. As far as lifting and carrying he answered that he can lift and carry heavy objects but has extra discomfort and also answered that he can lift and carry light to medium objects if they are conveniently positioned. He noted he is able to walk the same distance as in the past. He noted that he can do between moderate and heavy activity for at least 2 minutes. He has no difficulty climbing flight of stairs, some difficulty sitting 30 minutes to an hour as well as 2 hours but no difficulty standing or walking 30 minutes to an hour, some difficulty standing or walking 2 hours. He noted no difficulty with reaching and grasping for something off shelf at eye level and no difficulty doing it overhead, no difficulty with pushing and pulling activities, some difficulty with gripping, grasping, holding, and manipulating objects with hands, some difficulty with repetitive motion such as typing on computer but no difficulty with forceful activities with arms and hands, some difficulty with kneeling, bending, and squatting.

Sleep is greatly disturbed indicating 3-5 hours of sleeplessness since the injury. Sexual activity is a little less frequent because of injury. Noted no pain at the moment but mild pain most of the time. He indicated no interference with travel, no interference with recreational activities, no interference with social activities, no interference with concentration and thinking, and some or little of the time has mild depression or anxiety.

REVIEW OF RECORDS:

I reviewed the current submissions as well as my file. In the prior evaluation in July [redacted] his blood pressure was 130/94, weight was almost comparable [redacted] lbs. versus current [redacted] lbs. I

noted he had borderline control of hypertension and had ischemic treadmill. I concluded in the supplemental report he had Class 2 impairment with 10% WPI for hypertension, the gastrointestinal was Class 2 with 10% as well indicating the irritable bowel, at that time there was no evidence of upper gastrointestinal problem only the irritable bowel. He subsequently had the CT angiogram, reported in the last report of [redacted] and the findings supported the Class 3 with 30% for hypertension, based on ventricular hypertrophy documented on the imaging.

The note by Dr. [redacted] from August [redacted] indicates temporary total disability from August [redacted] to September [redacted], [redacted], does not provide data. Another form reflects the same. There is another disability certification between October [redacted], [redacted] and November [redacted] then December [redacted] through January [redacted], [redacted] not clear how such long extension can be made without evidence. There is another copy of January [redacted] which indicates that the prior form probably had a typographical error and this extension is to February [redacted].

The prescription pad note indicates that due to the condition he was advised to remain off work from July [redacted] and may return August [redacted]. Restrictions were difficult to read. There is another prescription pad note noting basically the same then a PR-2 report noting hypertension without information. It is undated.

The Application indicates request for expedited hearing. It is by honorable WCAB Judge [redacted].

Copy of Award dated February [redacted] reflects the settlement of the claim with no specific detail except the attorney fee. Petition to Reopen for new and further disability was noted, filed on August [redacted].

I should note that my office called the parties on December [redacted] asking for cover letter which was eventually submitted. However, I did not receive his medical records.

DIAGNOSTIC IMPRESSIONS:

1. Orthopedic problems deferred.

2. Hypertension out of control.

3. Irritable bowel.

DISCUSSION:

I had the opportunity to examine [redacted] at my Sherman Oaks office on December [redacted] in a comprehensive internal medical and cardiovascular evaluation considering he had a prior evaluation in July [redacted]; that claim settled with an Award but he filed Petition to Reopen for new and further disability.

I was provided disability slips by Dr. [redacted], his treating physician, but those contained no evidence just conclusion that he has temporary total disability. There is no evidence such as blood pressure data or any other issues. Submission of the actual medical records would be helpful to establish the interval change since the prior evaluation and the award.

However, considering that his weight is essentially unchanged, was [redacted] lbs. at my office and [redacted] lbs. in the [redacted] evaluation but current blood pressure is higher than the prior one and there is no indication that there is a change in treatment. Therefore, there appears to be an incremental change in his hypertensive disease. On current echocardiogram he has dilated left atrium at 4.6 cm and he has concentric hypertrophy between 1.3 and 1.5 cm. His right ventricular systolic pressure is in normal range at 26 mmHg. In the 2018 evaluation the echocardiogram revealed normal systolic and diastolic function, I did not find hypertrophy. However, Dr. [redacted] in the CT angiogram identified borderline hypertrophy with measurements of septum and lateral wall at 11 mm. The current echo measurements appear to be substantially greater. This may not be the most accurate considering it is not an easy measurement in a large person. However, there is an incremental change.

Considering that blood pressure is higher on the same treatment, and there is indication of increased hypertrophy even though the timeframe between [redacted] and current evaluation would not support such significant change. It takes time to develop hypertrophy unless he had uncontrolled hypertension since the prior evaluation.

Considering that previously I indicated 30% Whole-Person impairment with the current level of hypertrophy and lack of control of hypertension it is my opinion that there is an incremental increase of 5% - he currently has <u>35% Whole-Person impairment</u>. This incremental change represents new and further disability. Treatment must be intensified either by adding

another different antihypertensive class medication or increasing the dose. It is preferred to add another medication considering that sometimes increasing dosage causes adverse effects.

The current injury claims heart, hypertension, and hemorrhoids on a continuous trauma basis. I would like to review his medical records before commenting on his gastrointestinal tract or hemorrhoids. Review of records would also be helpful for his hypertensive heart disease assessment but based on current imaging and exam I can conclude that there was the incremental change and increase in the disability level.

Considering his employment as a police officer and the fact he has hypertensive heart disease it is not apportionable according to SB-899 and Labor Code Section 3212. Treatment will continue to be industrial with appropriate medications selected by his treating specialist and periodic office visits frequency determined by his clinical status. He requires periodic blood testing for electrolytes, renal function, and lipid panel, and on annual basis echocardiogram, EKG, and potentially stress testing and imaging.

Hypertension is an asymptomatic disease as noted also in table 4-2 of the AMA Guides. Therefore there are no subjective factors of disability, the objective factors are determined by the blood pressure level and the echocardiographic imaging.

As I indicated his hypertensive heart disease is industrial without apportionment. Dr. [redacted] indicated temporary total disability but unfortunately without review of data I cannot answer yes or no. The blood pressure level at my office was elevated but not to a level to support temporary total disability. As far as temporary partial disability, it would only limit very heavy lifting considering it would increase blood pressure.

was medically retired because of his orthopedic problems as well as hypertension and whether he is a QIW - the question is moot but from the internal medical perspective he potentially could resume his usual employment.

I should also point out that his internal medical conditions are based on continuous trauma, there is no evidence of specific injury aggravation and therefore Benson apportionment is not

applicable. I considered [redacted] but there are no chapters or sections within four corners of the AMA Guides that would address his internal medical impairments more accurately or better than the sections quoted above.

When the records are provided I will issue a supplemental report and my conclusions may be subject to change. At this time there is clear evidence of interval progression of his hypertension related impairment and disability. It is documented objectively by echocardiogram and the blood pressure level.

If there are any additional questions those will be addressed in the next report hopefully with review of additional records.

DECLARATION:

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. Injured worker, [redacted], was evaluated on [redacted] in my Sherman Oaks, CA office. I personally performed this evaluation based upon the specific request from the parties. I was asked to physically examine and evaluate the injured worker, and to prepare a report to answer specific medical legal issues as stated in the cover letter. Please find a copy of the letter requesting this medical legal report attached to this report. Please also find attached the finalized attestation for the page count for the records reviewed for this medical legal report.

I have personally prepared this dictation, which was transcribed by a professional transcriber at AcuTrans Medical Transcription Services. The preliminary historical data were acquired by my assistant, P. D'Alberto.

Blood collection and handling were performed by Quest Diagnostics. Laboratory testing was performed by Quest Diagnostics, and I have interpreted those results.

ANCILLARY TESTING: Electrocardiogram was performed by Stephanie Ober, under my direct supervision.

DIAGNOSTIC STUDIES: Echocardiogram was performed by Anna Atayan, Echo Technician, under my direct supervision.

Pursuant to Labor Code Section (4620-4622 and 4625-4628),Title 8 Medical Legal Expenses Regulations 9795(c) and 9793 (n), the Medical Legal Evaluation and report of ( ) is based on AMA Guidelines to the Evaluation of Permanent Impairment 5th Edition. The following report is billed per medical legal billing codes effective 4/1/2021.

The following modifiers were also utilized:

[ ] -92 Performed by PTP

[ ] - 93 Interpreter needed for examination

[ ] - 94 Evaluation by AME

[XX] - 95 Performed by QME

[redacted]

[ ] - 97 Performed by Board Certified Internal Medicine Specialist for Toxicology Evaluation

[ ] - 98 Performed by Board Certified Internal Medicine Specialist for Oncology Evaluation

Based on CCR 9793(h), 9795 and Paragraphs (b), (c) and (d) the report is billed as a:

ML 201 (PTP/QME/PQME/AME - Comprehensive Medical-Legal Evaluation) ML202 (Follow-up Medical Legal Evaluation) ML 203 (SUPPLEMENTAL Medical Legal Evaluation)

Explanation of circumstances and justification for use of procedure codes:

[XX] ML 201 Comprehensive Medical Legal Evaluation PTP/QME/PQME/AME report - Flat rate $2015.00 Including first 200 pages of record review

[ ] MLPRR - Record review in excess of 200 pages @ $3.00/per page ____N/A____Attestation attached.

I verify and declare under penalty of perjury that the total number of pages of records reviewed as part of the Comprehensive Medical-Legal Evaluation OR Follow-up Medical Legal Evaluation was in excess of 200 pages, and the total number of pages reviewed for the preparation of this medical legal report is N/A.

Based on Labor Code 4663 and 4664 the following medical legal issues have been addressed AND INCLUDED IN THE MEDICAL LEGAL REPORT:

[X] - Addressing Causation of Permanent Disability

[X] - Addressing Apportionment

I certify under penalty of perjury that I have not violated Labor Code Section 139.3 and the contents of my report are true and correct to the best of my knowledge.

Date of Report: [redacted]

Signed this [redacted] day of Dec, [redacted] at Los Angeles County, California.

Paul J. Grodan, M.D., FAHA
Assistant Clinical Professor
Department of Internal Medicine
UCLA School of Medicine

PJG:at:bw (2943)

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SAMPLE REPORT #2

AGREED MEDICAL EVALUATION

Gentlepersons:

I was asked to evaluate [redacted] again on December [redacted]. He was previously evaluated on September [redacted] and July [redacted]. This is a new evaluation.

EDUCATIONAL, OCCUPATIONAL AND MEDICAL HISTORY:

[redacted] is a [redacted]-year-old male born on [redacted] in [redacted]. He came to United States in [redacted]. He was hired by the County of [redacted] on [redacted]. He reported no issues in prior jobs. In the past employment he worked with disabled individuals.

County of [redacted] hired him as a correctional officer. Those details were outlined in the [redacted] evaluation and will not be

repeated. At that time hypertensive versus viral cardiomyopathy was suspected in addition to obesity, hypertension and mild insomnia.

[redacted] is still employed with the Correctional facility. He works full time doing office work. He is supposed to be full duty. He noted that he has anxiety attacks. He noted he had an ER visit at San Gorgonio Memorial Hospital and was transferred to Kaiser Riverside in April 2021. He was in hospital one day and then sent home. He had anxiety and was referred to psychiatrist.

On April [redacted] he was at work when he felt stressed out. Blood pressure was elevated and anxiety. He noted that paramedics were called, arrived, and he had "4 shots of nitro" and he calmed down.

At that time he was operating the doors. He noted "just too much 3-4, 12 hour shifts".

[redacted] was treated then discharged same day from [redacted]. This was on April [redacted]. He was advised to followup with his primary care physician Dr. [redacted] in [redacted]

He reported anxiety which was severe, noted headaches frontal to the back of the head on daily basis mostly at work. He takes Atarax 10 mg one or two pills daily for anxiety. However it causes drowsiness. He is unable to take it during the day.

He has used CPAP since his heart attack 2½ years ago. He noted that medication causes him to wake up. It occurs randomly in panic.

He indicated that his wife advised him that he also moves his legs in bed at night as if he was running. He wakes up tired in the morning. He noted that he wakes up at night at least once and feels "antsy and frustrated". It occurs 3-4 times during the week. At times he is unable to sleep all night even with CPAP. He noted he naps in daytime.

Sleep is interrupted 2-3 times weekly. He will wake up in fear as if he was involved in some stuff. He noted that he deals with level 4 prison both men and women. He noted that he lost about 2 weeks from work associated with the April [redacted] occurrence.

noted that he had psychotherapy. He had group therapy on the phone, he did not like it at all. He felt limited as to what he could share. He held back a lot. He noted that he had face to face sessions total of 8 - which did help.

feels useless, is limited with activities. He is at work full time but only in the office doing paperwork. Therefore he feels "antsy". He noted that he will leave for a walk periodically. He noted there is no inmate contact as far as he is concerned.

Energy level "sucks". He noted that he was very active in the past. He always exercised and now with walking has lower back pain and gets to the point he must stretch out.

The primary care physician will email him the disabled placard form for the DMV. He noted that he gets easily winded. He gets winded walking or if he is active. He noted psychological issues. He had MRI of the brain on March [redacted] due to a blackout. It was told to him was normal.

noted that he sustained a collapsed left lung. He noted that it felt like not enough air and was breathing fast and it resolved. He had breathing treatments at home.

He noted he does not smoke. He smoked in grade 7 but didn't since.

He noted that in [redacted] is his psychologist. Next appointment was scheduled for January [redacted].

He noted that it is difficult to get appointment with his primary care physician.

He is taking Zebeta and Cozaar and noted cholesterol is controlled with Crestor; also takes Lasix 20 mg. He consumes at least a gallon of water noting difficulty with weight loss. Appetite fluctuates. He modified his diet for exercise and noted that he is on low salt diet. He had no blood work since April [redacted]. Energy level is diminished. Recently he had diagnosis of hiatal hernia made in about [redacted]. He reported acid reflux. He eliminated all spicy and fried foods.

He noted breathing complaints, shortness of breath, winded easily. He has concern over use of force with inmates. He gets anxiety over if he is able to defend himself.

The day of this visit he is a little tired, unable to use his CPAP. He did not use it last night. He is frustrated. He tries to use CPAP nightly. At times with naps he is feeling well.

His hearing is limited intermittently. He reported about vision that eyebrow on the left is somewhat bothering but he still has blurry vision. Due to anxiety he will clench his teeth and develop brown crown.

On the health questionnaire chief complaint was left blank.

PAST HISTORY:

He denied childhood illnesses. He noted vasectomy in [redacted], eyelid surgery for lazy eye 4 months ago.

FAMILY HISTORY:

Father unknown, he has no information. Mother is [redacted] years old and evidently has high blood pressure. Three sisters, one deceased, two alive at [redacted] and [redacted] unknown health. He did indicate maternal hypertension, no other familial illness.

SOCIAL HISTORY:

[redacted] noted [redacted] not [redacted]. He noted this has occurred for the last 8 months. He rarely has alcohol and doesn't smoke. Current medications he listed as aspirin 81 mg daily, Lasix 20 mg daily, Crestor 5 mg daily, Zebeta 5 mg b.i.d., Losartan 25 mg daily, Pepcid 40 mg daily but evidently discontinued Protonix and Pepcid, takes Atarax once or twice a day 10 mg. He indicated [redacted] are healthy.

REVIEW OF SYSTEMS:

Noted sleeping 5-6 hours nightly and snoring as well as noted headaches, dizziness, visual complaints noting blurry vision, decreased hearing acuity, high blood pressure, chest pain,

palpitations, exertional dyspnea, swelling of ankles, and noted abdominal pain described as soreness.

He did indicate the headaches are from front to back, pressure feeling, no medication is taken for it and it "just get away".

PHYSICAL EXAMINATION:

[redacted] is an obese Hispanic male in no distress.

VITAL SIGNS:	HEIGHT:	[redacted]
	WEIGHT:	[redacted] lbs.
	BP:	138/96 large cuff
	PULSE:	64, regular
	RESP:	18
	TEMP:	Afebrile
HEAD:		Not examined due to Covid-19 and masking.
EYES:		Not examined due to Covid-19 and masking. Left eye there is a droopy eyelid.
ENT:		Not examined due to Covid-19 and masking.
NECK:		No thyroid palpable, no bruit, supple, no nodes.
CHEST:		Obese, clear, no rales or rhonchi.
HEART:		No murmurs, gallops or clicks, regular rhythm.
ABDOMEN:		Obese, soft, no organomegaly, masses, tenderness, bruits or hernias.
EXTREMITIES:		Pulses full, no edema, no clubbing or cyanosis, no deformity.
NEUROLOGICAL:		Deep tendon reflexes symmetrically absent, no focal or lateralizing findings.
SKIN:		No lesions.

LABORATORY INVESTIGATIONS:

Complete blood count, platelet count, and sedimentation rate was within normal limits.

Urinalysis was clear except 1+ protein.

Serum iron, T4, magnesium, and uric acid were in normal range.

Chemistry panel was entirely normal except glucose 133.

Lipid profile revealed cholesterol of 86, HDL was low at 25, triglycerides 321 high, non-HDL cholesterol was 61 normal range and cholesterol/HDL risk ratio of 3.4 which is favorable. However the total cholesterol was very low. This suggests liver failure.

Lipoprotein(a) was less than 10 which indicates low risk of cardiac events.

Glycohemoglobin A1c was 5.8% which is in the lower end of prediabetes.

Helicobacter urea breath test did not detect Helicobacter pylori.

Allergy panel, a Respiratory Allergy Profile Region XIII was obtained and revealed RAST class 0 reaction to cockroaches, white mulberry, Johnson grass, mouse urine protein, D. pteronyssinus and D. farina dust mites, Penicillium notatum, Cladosporium herbarum, Aspergillus fumigatus, Alternaria alternata, alder tree, mountain cedar, olive tree, walnut tree, cottonwood. Also noted class 0 response to common ragweed, mugwort, oak tree, elm tree, and Bermuda grass. He had class 1 reaction to rough pigweed, cat dander, dog dander. Class 2 reaction to Russian thistle and class 3 reaction to Timothy grass. The IgE level however was normal at 23.

Chest x-ray was obtained at Grove Diagnostic Imaging and Dr. Alore reported no active disease, no change from the July 29, 2020 exam. Lungs were clear. **Report is enclosed.**

Resting EKG revealed sinus rhythm rate of 59 with normal intervals and nonspecific T-wave flattening. No diagnostic abnormality.

Echocardiogram at my office revealed normal contractility, normal ejection fraction, no hypertrophy but left atrium dilated at 4.6 cm, right ventricle at 3.8 cm, the left ventricle also dilated at 6.0 cm. Ejection fraction was 70%. He had trace

mitral and pulmonic, mild aortic and mild to moderate tricuspid regurgitation. The calculated right ventricular systolic pressure was 37 mmHg. Except for dilated left atrium and left and right ventricle the study was unremarkable. **Full report is enclosed.**

He also completed the Epworth Sleepiness Scale questionnaire with a score of 12 indicating slight chance of dozing or sleeping while sitting and reading, sitting inactive in public place, sitting and talking to someone and in a car while stopped few minutes in traffic. Noted moderate chance while watching television, passenger in a car for an hour without a break, laying down to rest in the afternoon and sitting quietly after lunch without alcohol.

completed the 6-page ADL questionnaire noting that any issues are due to his back pain. He answered that he can look after himself normally without discomfort but he can only lift and carry heavy objects and does have extra discomfort. Injury and discomfort prevent walking more than one mile. The next question was whether he can do moderate activity for at least a day or 2 minutes. He answered he can do moderate activity. He noted some difficulty climbing flight of stairs, some difficulty sitting 30 minutes to an hour or 2 hours and some difficulty standing or walking 30 minutes to an hour, lot of difficulty standing or walking 2 hours, some difficulty reaching and grasping for something off shelf at eye level, some difficulty with reaching and grasping for something off shelf overhead. He answered some difficulty but still can perform. Again the question was whether he can reach and grasp something off shelf overhead and answered with some difficulty, noted some difficulty with pushing and pulling activities, some difficulty with gripping, grasping, holding, and manipulating objects with hands, some difficulty with repetitive motion such as typing on computer, some difficulty with forceful activities with arms and hands, some difficulty with kneeling, bending, and squatting.

Sleep is moderately disturbed indicating 2-3 hours of sleeplessness since the injury. Sexual activity is much less frequent because of injury. However he has no pain at the moment, no pain most of the time. Some or little of the time has interference with travel, some or little of the time interference with recreational activities, some or little of the time with ability to engage in social activities, noted some or little of the time injury and pain interfere with concentration

and thinking. Also noted all the time has severe depression or anxiety and cannot work.

REVIEW OF RECORDS:

I reviewed my prior reports in detail as well as the current submission with attestation of **453 pages**. My prior two reports consist of 29 pages total.

Primary treating physician's telephone appointment report dated July [redacted] by [redacted], DO noted . is placed off work through August [redacted]. . was seen for myocardial infarction. He will be started on trial light duty at the end of next month. Diagnosis was 1) Combined systolic and diastolic heart failure, acute on chronic. 2) Palpitations. 3) Cardiomyopathy, unspecified.

Lab report dated July [redacted] was from my office and was previously reviewed and considered.

PTP supplemental report dated September [redacted] by [redacted], DO noted is placed on modified activity at work if available and at home through October [redacted] He should not be placed in a combative situation, no direct inmate connection. reported he has been doing home exercises with a personal trainer. Noted some improvement but feels it is not enough.

AME report by [redacted], DO is dated January [redacted] . was diagnosed with cardiac issues to include hypertension, congestive heart failure, sleep apnea, and hiatal hernia. He was able to recall current medications as Lasix, Cymbalta, Protonix and aspirin but noted there are others he was unable to recall. He has occasional alcohol in the past until he was prescribed medication, now he does not drink at all. He does not smoke. Current weight was [redacted] lbs. It was noted has been in law enforcement for about [redacted] years and has a history of hypertension for few years. He last worked December [redacted] when he started having heart problems including difficulty breathing and his wife took him to the hospital. He was placed on restrictions to include no inmate contact, no participation in fights and therefore he has not worked since. He reported complaints of dizziness at that time described as a sense of vertigo 3-4 times a week onset sudden. Impression was 1) Dizziness. 2) Neurocysticercosis. has no fixed

neurologic deficits on examination such as cerebellar dysfunction or balance impairment and his ocular movements do not appear abnormal. Differential diagnosis includes electrical phenomena, vascular phenomena, and non-neurologic phenomena. Imaging with MRI and EEG with telemetry will help provide accurate diagnosis. Currently he is not permanent and stationary and more information is necessary including the solidification of the neurologic diagnosis. Medical records are being requested due to lack of information to establish exact apportionment at this time. At this time will likely have a 3% WPI for intermittent dizziness episode. However, medical records surrounding hospitalization, a neurologic workup could significantly change especially if there is evidence of potential seizure disorder. Causation cannot be clearly attributed at this time to the workplace or to cardiovascular disease. However has not been excluded.

Brain scan without contrast from SimonMed dated March [redacted] by Dr. [redacted] impression was 1) There is no acute intracranial abnormality. 2) Small retention cyst or polyp is present within the right maxillary sinus, there is also trace mucosal thickening in the left maxillary sinus. 3) There is a 10 mm polypoid focus along the right paramedian aspect of the posterior nasopharynx, correlate with direct visualization is suggested.

Subpoenaed records from [redacted] Hospital were reviewed. AMR dated April [redacted] is a ground transport for complaint of chest pain. . was transported from Smith Correctional facility in Banning. Blood pressure was 190/142, 119/71, heart rate 105. EKG noted sinus rhythm. He was administered nitroglycerin paste 2% and transported to San Gorgonio Memorial Hospital in Banning, California.
reported gradual onset of chest pain and pressure that he thought would go away but got to be 10/10 non-radiating pain. He reported he had a heart attack in the past. A 12 lead showed no STE or STD. He was hypertensive on the cardiac monitor and was given 324 mg of aspirin. Blood pressure with paramedics was 190/142. Blood glucose 98. Blood pressure follow-up was 119/71, pulse 105, blood pressure again was 113/51, pulse 110 and 99. Blood pressure 133/79, pulse 94. He was noted to be alert.

ER report from San Gorgonio Memorial Hospital by Dr. [redacted] dated April [redacted] noted admitting diagnosis chest pain, unspecified. Other diagnosis was 1) Hypertensive heart disease

with heart failure. 2) Heart failure, unspecified. 3) Gastroesophageal reflux disease without esophagitis. 4) Sleep apnea, unspecified. 5) Old myocardial infarction. 6) Long term use of aspirin. 7) Other long term drug therapy. 8) Contact with and suspected exposure to Covid-19.

ER note dated April [redacted] noted . was brought in by ambulance with complaints of chest pain started one hour ago. He was given nitro-spray plus aspirin 324 mg and nitro paste. Pain scale is 1/10. He denied any travel or exposure to international traveler. Current medications are Lasix, Zebeta, aspirin 81 mg, Protonix and Cozaar. He is a never smoker. Heart rate was 88. is positive for malaise, chest pain, and dyspnea. Current medications are aspirin 81 mg, famotidine 40 mg, bisoprolol 5 mg twice daily, Losartan 25 mg twice daily, Lasix 20 mg, and Protonix 40 mg.

April [redacted] chest x-ray by Dr. [redacted] noted no acute cardiopulmonary disease.

April [redacted] ER triage note - chief complaint was chest pain. Blood pressure 136/79, heart rate 88, weight [redacted] lbs., BMI 38.0. Repeat blood pressure was 105/70, temperature 96.2. At this time reported chest pain 2/10. Dr. Preci was at bedside. He was able to walk to the bathroom without assistance. Dr. Preci will leave the nitroglycerin paste front of chest. Discussion was made of possible transfer to Kaiser.

Discharge report by Richard Preci, DO dated April [redacted] noted blood pressure 110/48, 104/58.

Subpoenaed records of [redacted] were reviewed. Ophthalmology TAV by Dr. [redacted] is dated March [redacted] is a preoperative evaluation. Diagnosis was 1) Left brow ptosis. 2) Left dermatochalasis.

Email to Dr. [redacted] dated [redacted] by indicating he is returning to work the following month and would like some help regarding side effects of dizziness, fatigue, shortness of breath, and tightness in the chest area. He noted eye surgery is on April [redacted]. He is asking if there is restriction on his job duty since he will be responding to emergencies. Also noted his disabled placard is about to expire and would like to have it renewed. Response from Dr. [redacted] is that the placard is ready, last echocardiogram was good and

limitation should be measured by how he is feeling. In the event he is unable to tolerate certain things at work possibility is to decrease work hours.

April [redacted] nasal swab for Covid-19 - not detected.

Postoperative exam dated April [redacted] by Dr. Chang noted healing well, no infections. Assessment was 1) Left brow ptosis. 2) Left dermatochalasis.

Emergency prospective review program dated April [redacted] by Dr. [redacted] noted [redacted] presented to [redacted] Hospital with chest pain. He has a history of prediabetes, esophagitis. Blood pressure 136/79, 104/58, pulse 88 and 61. Plan is for transfer to [redacted] however they declined due to unsafe conditions and a prolonged wait. Case was discussed with Dr. [redacted], who graciously accepts patients to the ER.

May [redacted] encounter exam by Dr. [redacted] for atypical chest pain. [redacted] reported to Dr. [redacted] that he had an incident at work, was transported to [redacted] Hospital and was later transported at [redacted]. He also noted the physicians at San Gorgonio requested a stress test which was never done. Currently he is requesting additional time off work since he is not ready to return. He reported feeling frustrated, anxious with headaches, dizziness, muscle tension, chest tightness, and exhaustion. He is requesting an appointment.

Office visit dated May [redacted] noted blood pressure 118/77, pulse 71, weight [redacted] lbs., BMI [redacted]. [redacted] is requesting work slip. [redacted] never had Covid vaccination. [redacted] was seen in the emergency department February [redacted] with atypical chest pain likely associated with anxiety and high blood pressure. He was seen by his primary care physician and echo noted normal LVEF and normal diastolic function. He was noted to be anxious, reported ongoing stress, anxiety, various complaints of palpitations along with constant chest pain and fatigue. He reported episodes of random fatigue and shortness of breath however all recent studies were normal. His complaints are worst at work; he is concerned that he will be unable to defend himself in the prison. Assessment was shortness of breath. He is to remain off work through May [redacted]

Ophthalmology evaluation dated May [redacted] Dr. [redacted] is a postop follow-up. Weight [redacted] lbs., BMI [redacted] A1c was 5.7% dated October [redacted] He was noted to be healing well, no infections on right and left brows.

Telephone encounter dated June [redacted] - an email addressed to Dr. [redacted] from [redacted] who noted he completed therapy that was recommended however stress and anxiety level is still high. He is taking medication for anxiety which does help him sleep, is not able to take in the daytime since it causes drowsiness. Since he completed therapy he is referred to work. At this time [redacted] is requesting a doctor's note saying he is cleared to return to full duty. He is placed off work through June [redacted], [redacted]

July [redacted] SARS-COV-2 qualitative test - not detected.

Discharge report by Dr. [redacted] dated April [redacted] noted he was admitted on the same day. Blood pressure was 143/87, 153/95, 134/86, pulse 61, 66, and 56. He is discharged in stable condition. He had brow lift left side, blepharoplasty left side.

Operative report dated April [redacted] by Dr. [redacted] is for left direct brow left, functional blepharoplasty left upper eyelid. Postop diagnosis was 1) Left brow ptosis. 2) Left upper lid dermatochalasis. Patient tolerated the procedure well.

April [redacted] Dr. [redacted] noted [redacted] presented with chest pain onset prior to 1 p.m. Pain resolved with nitro, negative workup, negative serial cardiac enzymes, clean cath in January [redacted]. He has a history of prior non-ischemic cardiomyopathy but recent normal ejection fraction, normal diastolic ejection fraction, he was transported via EMS from San Gorgonio with complaints of chest pain while at work today. Blood pressure was 162/100, pulse 70. Subsequent blood pressure was 121/70, pulse 70.

Chest pain is not consistent with acute coronary syndrome with cath history and troponin negative x3. No indication for admission. Diagnosis was <u>atypical chest pain</u>. He will be discharged home in stable condition. He should follow-up with his primary care physician or cardiologist in the next one to two weeks.

When I evaluated in September [redacted] his weight was in the range that he had documented in the records, he was at [redacted] lbs. but his blood pressure was elevated at 142/102 but he had blood pressures even higher than that noted in the file.

The exercise study was not very helpful; notwithstanding instructions what to do and not to do, stepped off the belt prematurely while the belt was still moving at speed but maximal stress test was not obtained. He only was at 65% of maximal heart rate for age. He did have hypertensive response and he claimed dizziness. It appears that the major element is anxiety as there was no medical reason for him to step off the belt. He did not have any specific discomfort he only complained of dizziness, he was hyperventilating. That is consistent with panic or anxiety. His maximal heart rate was only 115 or 65% of predicted maximum.

The echocardiogram revealed no hypertrophy, only dilated left atrium, as well as right ventricle, and he had an elevated right ventricular systolic pressure at 39 mmHg. I noted as a primary impression suspicion of viral/hypertensive cardiomyopathy which was resolving.

After review of records I noted for his hypertensive heart disease Class 2 impairment with 15% WPI. However I addressed it under the section of cardiomyopathies section 3.5, page 47, table 3-9. Reason was that - the recovery course suggests a viral not ischemic cardiomyopathy and I pointed out that he did have catheterization in January 2019 which showed normal coronary arteries. Therefore did not have a "heart attack", he did not have ischemic heart disease he had manifestation of disease of the heart muscle or cardiomyopathy. I noted that he needs re-evaluation because he was temporarily totally disabled. I did address the gastrointestinal tract and that is currently unchanged.

He did have re-evaluation on July [redacted] at which time hypertensive nonischemic cardiomyopathy resolved was the impression. That resulted in change to 10% Whole-Person impairment in Class 2 and I did indicate hypertensive disease in Class 2 category as well. He did have proteinuria. That is currently still present at 1+.

DIAGNOSTIC IMPRESSIONS:

1. Hypertension controlled.

2. Nonischemic cardiomyopathy controlled.

3. Obesity.

4. Hiatal hernia unchanged.

5. Orthopedic injury deferred.

6. Hypertriglyceridemia.

7. Mild insomnia disorder rule out sleep apnea.

DISCUSSION:

I partly offered a discussion above under review of my reports however the current evaluation reveals no change in his gastrointestinal system, as far as the nonischemic cardiomyopathy that has stabilized with no evidence of hypertrophy, no evidence of contractility disorder with a normal ejection fraction but he does have dilated left ventricle, dilated left atrium and right ventricle, and for that reason he does have some residual abnormalities that support the 10% Whole-Person impairment for cardiomyopathy. Furthermore there is documentation of hypertension and even though the cardiomyopathy is most likely related to hypertensive disease, unless there was a viral myocarditis which is difficult to prove or disprove at this point, but the hypertension is rated separately and the cardiomyopathy will be combined via CVC. As far as the hypertensive disease with the findings on the echocardiogram he has a Class 2 impairment with 10% Whole-Person impairment.

Considering there is overlap in disability between cardiomyopathy and hypertension the two impairment ratings are combined via the combined values chart.

As the Joint AME letter indicated had a subsequent incident which led to San Gorgonio Hospital on April [redacted]. The question is whether it is separate incident or continuation of the continuous trauma claim.

The records from [redacted] Hospital revealed that on April [redacted] he was transported to the hospital with reported chest pain. His blood pressure noted by the EMS was **190/142** which was severely elevated but subsequent blood pressure was normal at **119/71**. It clearly was a major occurrence of anxiety which was probably magnified by the perception of having chest pain. EKG showed no changes. He did not have myocardial ischemia which he could not have with normal coronary arteries in any case. Subsequently his blood pressures were in the low normal range. The assessment was hypertensive heart disease with heart failure but I have not seen any documentation that he was in heart failure. The hiatal hernia and gastroesophageal reflux was a stable ongoing problem. I should point out that he had a chest x-ray on April [redacted] which did not show heart failure. Therefore the diagnostic label of congestive heart failure was not supported by evidence.

The occurrence was transient and can be considered as a separate specific event. It was associated with a sudden significant rise in blood pressure but did not cause a residual incremental increased impairment or disability. Considering his blood pressure was easily controlled after his initial admission pressure I cannot find any residuals that can be rated. He was transported from work at Smith Correctional facility in Banning and therefore I would consider that occurrence industrial. The associated temporary disability whether it was a day or a week would be industrial. The fact that subsequently all blood pressures were normal indicate that he was stable for return to work.

The records that I reviewed do not show any encounters subsequent to April [redacted] to indicate followup until mid-July [redacted] when he was tested for Covid-19 and was negative. Blood pressure remained reasonably controlled even though higher than noted from San Gorgonio. It appears he was cleared for full duty on June [redacted] but based on the records of [redacted] I do not find that his temporary disability persisted until that date since there are no interval visits unless additional records are submitted to support the extension of the TTD through June [redacted], [redacted] date. There were some records such as Dr. [redacted] visit in May [redacted] only about a week after San Gorgonio and he is described as anxious and having atypical chest pain which was actually listed back in February [redacted]. Therefore it appears to be a recurrent bout of anxiety or panic. That would require a <u>psychological assessment.</u>

Reviewing some of the records from the file by Dr. [redacted], reported episodes of random fatigue, shortness of breath, and claimed complaints were worse at work and he was concerned it is evident that the major element is anxiety. The records also reflect that he had stress and anxiety complaints in [redacted] as well.

In summary, the April [redacted] event was a separate specific occurrence, a consequence of psychological issues and not cardiovascular. remains permanent and stationary or MMI. I have identified the cardiomyopathy section from the AMA Guides, the hypertensive section is page 66, table 4-2 and there are no other sections or chapters within the four corners of the AMA Guides that would more accurately or better reflect his internal medical impairments.

In summary I identified his medical conditions, I noted the nexus to employment considering that he was taken by ambulance from work and therefore work circumstances were the precipitating factors. He was not able to provide more details in that regard when questioned. He did not report specific occurrences at that time except onset of chest pain. In my opinion if there was a period of temporary total or partial disability it was on psychological basis considering he has normal coronary arteries, considering he has no anatomical impairment of his cardiovascular system but he did have hypertensive measurements related especially to bouts of anxiety. That was also documented at my office previously during the treadmill study at my office.

I addressed Almaraz-Guzman above. There is no apportionment according to Benson considering the issues of hypertension and hiatal hernia and reflux are based on continuous trauma. The specific occurrence did not impact those conditions causing an incremental change.

I considered apportionment according to Labor Code Section 4663 and 4664. He is a correctional officer and the cardiovascular issues are presumptive without apportionment, no data to rebut.

I have not found any subsequent injury or subsequent increase in disability.

The treatment he received was appropriate, necessary and in compliance with ACOEM and MTUS Guidelines. He does require

treatment of his blood pressure with medications at the selection by his treating physician based on efficacy in blood pressure control and adverse effect profile. He requires periodic followup visits which are determined in terms of frequency on the basis of his clinic status and periodic determination of his electrolytes, renal function and lipid panel via blood testing. He should have annual echocardiogram, EKG, and potentially exercise study and imaging if necessary.

Hypertension is a disease which can be controlled but not cured therefore treatment is indefinite.

I agree with his release to work. He is not a QIW. Based on the objective data he is not restricted from work as a correctional officer.

However, I have to amend partly my above statements considering that upon rereview of my initial assessment in September [redacted] I noted that he works as a [redacted] but nonsworn. Therefore, if the presumption does not apply to him the comment about absence of apportionment would obviously be incorrect. However, I have not found other factors, he was hired in [redacted] and his internal medical conditions evolved in the course of his employment. He did not report family history of hypertensive disease or any cardiovascular issues in the family. Obesity can be an aggravating factor however I have not found in the review of records a correlation between his obesity and change in blood pressure.

Should he have a psychological assessment by an AME/PQME I will review the report and provide additional comments if necessary. There is substantial evidence in his direct history as well reviewed records that the major component is psychological with anxiety episodes and that would be the common denominator for his symptoms he reported.

Should there be any further questions or any points that were missed it will be addressed in my next report if necessary.

DECLARATION:

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. Injured worker, [redacted] was evaluated on [redacted] in my Rancho Cucamonga, CA office. I personally performed this evaluation based upon the specific request from the parties. I was asked to physically examine and evaluate

the injured worker, and to prepare a report to answer specific medical legal issues as stated in the cover letter. Please find a copy of the letter requesting this medical legal report attached to this report. Please also find attached the finalized attestation for the page count for the records reviewed for this medical legal report.

With the large volume of records I was assisted in excerpting from medical records by P. D'Alberto in arranging all records in chronological order and preparing the summary of records. I then personally reviewed all the medical records and summary prior to using all or part of it in preparation of my report. I have personally prepared this dictation, which was transcribed by a professional transcriber at AcuTrans Medical Transcription Services. The preliminary historical data were acquired by my assistant, P. D'Alberto.

Blood collection and handling were performed by Quest Diagnostics. Laboratory testing was performed by Quest Diagnostics, and I have interpreted those results.

ANCILLARY TESTING: Chest x-rays were performed at Grove Diagnostic Imaging by Dr. Alore. Electrocardiogram was performed by Stephanie Ober, under my direct supervision.

DIAGNOSTIC STUDIES: Echocardiogram was performed by Anna Atayan, Echo Technician, under my direct supervision.

Pursuant to Labor Code Section (4620-4622 and 4625-4628), Title 8 Medical Legal Expenses Regulations 9795(c) and 9793 (n), the Medical Legal Evaluation and report of is based on AMA Guidelines to the Evaluation of Permanent Impairment 5th Edition. The following report is billed per medical legal billing codes effective 4/1/2021.

The following modifiers were also utilized:

[ ] -92 Performed by PTP

[ ] - 93 Interpreter needed for examination

[XX] - 94 Evaluation by AME

[ ] - 95 Performed by QME

[ ] - 97 Performed by Board Certified Internal Medicine Specialist for Toxicology Evaluation

[ ] - 98 Performed by Board Certified Internal Medicine Specialist for Oncology Evaluation

Based on CCR 9793(h), 9795 and Paragraphs (b), (c) and (d) the report is billed as a:

ML 201 (PTP/QME/PQME/AME - Comprehensive Medical-Legal Evaluation) ML202 (Follow-up Medical Legal Evaluation) ML 203 (SUPPLEMENTAL Medical Legal Evaluation)

Explanation of circumstances and justification for use of procedure codes:

[XX] ML 202 FOLLOW-UP Medical Legal Evaluation which occurred within 18 months of the date on which a prior Med-Legal evaluation took place, Including first 200 pages of records review - Flat Fee of $1,316.25

[redacted]

[XX] MLPRR - Record review in excess of 200 pages @ $3.00/per page __253___Attestation attached.

I verify and declare under penalty of perjury that the total number of pages of records reviewed as part of the Comprehensive Medical-Legal Evaluation OR Follow-up Medical Legal Evaluation was in excess of 200 pages, and the total number of pages reviewed for the preparation of this medical legal report is ___453_____.

Based on Labor Code 4663 and 4664 the following medical legal issues have been addressed AND INCLUDED IN THE MEDICAL LEGAL REPORT:

[x] - Addressing Causation of Permanent Disability

[x] - Addressing Apportionment

I certify under penalty of perjury that I have not violated Labor Code Section 139.3 and the contents of my report are true and correct to the best of my knowledge.

Date of Report: [redacted]

Signed this [redacted] day of Dec, [redacted] at Los Angeles County, California.

Paul J. Grodan, M.D., FAHA
Assistant Clinical Professor
Department of Internal Medicine
UCLA School of Medicine

PJG:at:bw (2948)

June 23, 2022

TO: Each Trustee
Board of Retirement

FROM: Ricki Contreras, Manager
Disability Retirement Services Division

FOR: July 6, 2022, Board of Retirement Meeting

SUBJECT: **DISMISS WITH PREJUDICE THE APPEAL OF ALVIN D. POFF, JR.**

Mr. Alvin D. Poff, Jr. applied for a service-connected disability retirement on February 19, 2021. On April 6, 2022, the Board denied his application for service-connected disability retirement.

Mr. Poff's attorney filed a timely appeal. On June 15, 2022, the applicant's attorney advised LACERA that his client did not wish to proceed with his appeal.

IT IS THEREFORE RECOMMENDED THAT THE BOARD:

Dismiss with prejudice the appeal of Alvin D. Poff, Jr. for a service-connected disability retirement.

FJB: RC: mb

Poff, Alvin D., Jr.docx

Attachment

NOTED AND REVIEWED:

Francis J. Boyd, Sr. Staff Counsel

Date: 06/23/2022

LACERA

FOR INFORMATION ONLY

June 22, 2022

TO: Each Trustee
Board of Retirement

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: July 6, 2022 Board of Retirement Meeting

SUBJECT: **Federal Legislative Update**

LACERA's federal legislative advocates last gave an update to the Board of Retirement on December 1, 2021. Our legislative advocates, Tony Roda of Williams & Jensen and Shane Doucet of Doucet Consulting Solutions, are here today to provide an educational update of the latest developments in federal legislation.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

Attachment
Presentation by Tony Roda and Shane Doucet

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

LACERA
Board of Retirement Meeting

July 6, 2022

Federal Retirement & Health Care Update

- **Tony Roda,** Williams & Jensen, PLLC
- **Shane Doucet,** Doucet Consulting Solutions

Retirement Policy

1. SECURE Act 2.0
2. Social Security – WEP
3. Threats to Public Plans
4. Aid to States/Localities
5. Regulatory Activities

SECURE Act 2.0

- Bipartisan bills introduced in House and Senate
  - H.R. 2954, approved by full House
  - Senate: HELP and Finance Committee bills
- Key provisions included *or under consideration*
  - Age 75 RMD, recovering overpayments, additional catch-up for 62-64, Roth catch-up contributions, student loan repayments to be treated as elective deferrals for matching contributions, *removing pension plan "direct pay" requirement for 402(l) public safety retiree health care exclusion, and allowing certain non-profit firefighters to be in governmental plans*

Social Security

- Numerous bills to replace or repeal penalties for some or all public employees (permanent repeal of WEP/GPO, 5-year repeal of both, and WEP-only reform)
- Unclear whether consensus can be reached
- Cost of repeal may generate interest in mandatory coverage

Threats to Public Plans - Revenue Raisers -

- Rothification
- UBIT
- Financial Transactions Tax (FTT)

Federal Intervention Approaches

- Federal aid contingent on pension reform (ERISA funding rules or DC replacement)
- Forgivable loans contingent on benefit cuts, lower discount rates, removal of COLAs, etc.
- Tax-free POBs to close DB plans and replace them with DC plans and Social Security

Federal Intervention, cont.

Urban Institute Report (January 2022)

- ERISA – funding, discount rates, PBGC insurance
- SEC oversight of GASB
- Federal risk-free reporting requirement; condition tax-exempt bonding authority (i.e., PEPTA)
- Closer review of FICA-replacement plans

Aid to States/Localities

- Pensions used to argue against pandemic-related aid to states/localities
- Often confused with private pensions and funding relief to those plans
- Many attempts to impose restrictions on aid:

  "cannot be deposited into a state pension fund"

  "cannot supplant any liability that existed prior to the pandemic"

  "prohibition on state changes to pension programs that would increase pension payments"

American Rescue Plan Act
Enacted March 11, 2021

- Private Sector Pension Relief
  - Amends federal rules and insurance solely applicable to private sector, ERISA plans
- $350 Billion in State and Local Government Aid
  - Cannot “deposit into any pension fund”
  - “Deposit” defined as “an extraordinary payment into a pension fund for the purpose of reducing an accrued, unfunded liability”

Regulatory Activities

- Original SECURE Act
- Treasury-IRS: Definition of Governmental Plan, and final rules for Normal Retirement Age
- HHS-CAS: Audits of pension costs for federally-funded employees
  - Contributions greater than the ADC, including reserve funding

FTC Investigates PBMs

- The Federal Trade Commission launched an investigation (5-0 vote) on June 7 into the pharmacy benefit management industry following criticism of the middlemen and their role in increasing the price of prescription drugs.

- Six largest PBMs in the U.S. — CVS Caremark, Express Scripts, OptumRx, Humana, Prime Therapeutics and MedImpact Healthcare Systems — to turn over extensive information and records regarding their business practices, dating back five years.

- Reviewing: Fees PBMs charge unaffiliated pharmacies; methods to steer patients toward PBM-owned pharmacies; the prevalence of restrictions like prior authorizations; the impact of rebates and fees from drug manufacturers on formulary design; and the costs of prescription drugs to payers and patients…

PBMs v. Pharma

A message from PhRMA:

"Did you know that only three insurance company PBMs control 80 percent of the prescription drug market? They use their market power to get tens of billions in rebates and discounts that should be going to you. Tell Congress those savings belong to patients."

- Politico Ad 6/13/22

PBMs v. Pharma

"The PBM industry is the only stakeholder in the chain dedicated to seeking lower costs. PBMs do that work for the employer, union, health plan, and government clients who hire them, and, most importantly, the patients for whom those health plans provide coverage…PBMs return $10 in savings for every dollar spent on their services. As a result, PBMs will lower the cost of health care by $1 trillion this year alone. For many of us, that can be a hard number to get our heads around, but it comes down to saving about $962 per person per year."

- JC Scott, President and CEO of the

Pharmaceutical Care Management Association (PCMA)
before Senate Commerce Committee (5/5/22)

FDA User Fee Reauthorization Legislation

- Enables the FDA to collect fees from manufacturers of brand drugs, generic drugs, biosimilars and medical devices for another five years. In exchange, the agency pledges to hire additional review staff and expeditiously review product applications.

- The current five-year FDA user fee agreement expires at the end of September.

- House passed 392 to 28 on June 8 / Senate HELP Committee passed on June 13

Modernizing Accelerated Approval Act

- Makes improvements to the FDA's accelerated approval pathway, a regulatory mechanism that provides early access to treatments for patients with serious and life-threatening conditions.
  - Establishing a council of senior FDA leadership to ensure appropriate use of the accelerated approval pathway across and within FDA centers and divisions.
  - Requiring the Secretary to issue guidance on the use of novel endpoints and clinical trial designs in accelerated approval and on the expedited withdrawal procedures.

Medicare Trustee Report

- Medicare Not Broke Yet - The projected depletion date for Medicare's trust fund for inpatient hospital care moved back two years to 2028 from last year's forecast of 2026. At that time, the fund's reserves will become depleted and continuing total program income will be sufficient to pay 90 percent of total scheduled benefits.

- "Economic recovery from the 2020 recession has been stronger and faster than assumed in last year's reports, with positive effects on the projected actuarial status of the trust funds in these reports," the report states.

- Some uncertainty exists. The trustees set their assumptions for the report back in February. Officials said in a call last week that some data points, such as inflation and its impact on the cost of living, may have since moved.

CMS Analysis on 2022 Medicare Part B Premium Reexamination

- In November 2021, CMS announced that the Part B standard monthly premium increased from $148.50 in 2021 to $170.10 in 2022. This increase was driven in part by the statutory requirement to prepare for potential expenses, such as spending trends driven by COVID-19 and uncertain pricing and utilization of Aduhelm.

- CMS recently released a statement that it will pass lower-than-anticipated Medicare Part B spending when calculating Medicare Part B 2023 premiums.

- CMS stated they "*determined a mid-year administrative premium redetermination to not be operationally feasible, and also determined CMS does not have sufficient authority to send premium refunds directly to beneficiaries unless there is excess payment relative to the established premium*."

Skinny Build Back Better

Revenue	$ Billions	Notes
Intl and other biz reforms	$335	Changes re interest, Pillar 2 adaption, timing
15% corp AMT	$300	Further carve outs
1% buyback tax	$116	Delay until 2023
5%/8% AGI surtax	$200	Pass through exemption, possible delay
3.8% active income NIIT	$252	
Excess biz loss limit	$160	
IRS net investments*	$127	
Drug pricing	$250	
Other	$24	No fossil fuel sticks
Total Revenue	**$1,764**	
Spending	**$ Billions**	**Notes**
Climate	$500	No union EV credit
ACA premiums	$220	Made permanent
Medicaid gap	$180	Made permanent
Total Spending	**$900**	

Sources: Treasury, CBO, JCT, own estimates

*CBO's IRS estimate is $127B, Treasury's IRS estimate is $320B

Drug Cost Proposal BBB

- Rep. Susan Wild (D-PA) and 19 other House Democrats in competitive House seats sent a recent letter to Senate Majority Leader Schumer (D-NY) and Senate Finance Committee Chairman Wyden (D-OR) pushing them to include prescription drug pricing reform provisions in a reconciliation bill.

- Requested bill include reforms passed by the House last fall related to limiting the cost of insulin at $35 per month, capping out of pocket costs for seniors in Medicare Part D at $2,000 per year, penalizing drug corporations that raise prices faster than the rate of inflation, and, lastly, granting Medicare the authority to negotiate the prices of certain drugs.

Challenges for BBB

- Sen. Sinema (D-AZ) is opposed to increasing tax rates on the rich and large corporations.
- It’s uncertain whether the drug pricing provisions can pass the “Byrd rule” test
- Democrats are facing a time crunch since the fiscal 2022 reconciliation instructions expire Sept. 30. After that, they'd need to adopt a new budget resolution in order to pass a filibuster-proof package.
- Congress will recess in August, and there are just a few weeks in September after Labor Day to approve must-pass legislation like stopgap funding to avoid a partial government shutdown.

Positioning for 118th Congress

- Big Five for LACERA (Senators Feinstein and Padilla, and Reps. Chu, Sanchez, and Gomez)
- Likely have a GOP-controlled Congress alongside Biden's next two years in office
- Same dynamic as President Obama and GOP-controlled Congress (2010-2016)
- Interests of first responders resonate with GOP Members – highlight those issues
- However, likely that we'll be playing more defense than offense in the 118th Congress

Contact Information

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LACERA

June 28, 2022

TO: Each Trustee,
Board of Retirement

FROM: JJ Popowich, Assistant Executive Officer
Kelly Puga, Contact Center Manager
Gerald Bucacao, Sr. Retirement Benefit Specialist
Valerie Quiroz, Sr. Retirement Benefit Specialist
Renee Copeland, Sr. Retirement Benefit Specialist

FOR: July 6, 2022 Board of Retirement Meeting

SUBJECT: **MEMBER SERVICES CALL CENTER WAIT TIME**

The LACERA Call Centers have seen a historical trend of year over year increase in call volume, and a more intensive increase in calls over the last year and a half. This includes a dramatic spike in calls beginning in January of 2022. This call volume increase, along with other factors, has led to a steady rise in call wait-times. Recently, we received a Trustee request to add an informational discussion item to examine the underlying causes for the increase in wait times and discuss efforts to improve our service levels.

The management team recognized early on during the pandemic, and reported in past CEO reports and Operations Briefings, that the pandemic would have significant impacts on our ability to meet historical service level expectations in the Call Centers. In these reports we shared that we were experiencing a dramatic increase in the number of calls, especially those related to retirement counseling, and we were expecting staffing shortages due to the inability to hire and train staff during the height of the pandemic. We have also shared that we had initiated two Core Benefit Training classes to help get much needed staff ready to support members and address the protracted call wait times.

The following presentation will outline some of the underlying causes for the current spike in wait times, share insights into the performance of our highly dedicated and tireless staff who have risen to the challenge of adapting to the increased workloads, as well as the steps and projects the management team has taken to address the underlying call drivers.

Today's focus will be on Member Services. Retiree Healthcare will share a similar analysis at the August Board of Retirement meeting. It is important to keep in mind that while the two call centers are separate and focus on different parts of the member's benefits, they impact each other as members do not see the internal separation the same way that we do. For members, the service received by LACERA is that provided by both call centers. We are one LACERA and while we are focusing on Member Services in today's discussion, we can share that the trends we see in the Member Services' call center are mirrored in Retiree Healthcare's call center.

What is Driving the Increase in Call Wait Times?

Today's discussion will demonstrate that the current increase in wait times is the confluence of a historical increase in call volumes and several cyclical events such as, "March Madness", the annual 1099-R mailings, and the annual Part B verification process, that continue to place a high level of stress on our operations at specific times of the year, increases in the duration of calls, and staffing shortages due to the inability to hire during the pandemic and natural attrition and internal movement.

LACERA's Four Pillars of Call Center Management

In preparation for this discussion, we felt it would be helpful to share some insights into how we approach call center management. We have summed up this approach, which we have been employing since 2006, as LACERA's Four Pillars of Call Center Management.

Noted and Reviewed:

Santos H. Kreimann
Chief Executive Officer

SK:jj

Throughout this presentation we will demonstrate how we have been applying these principals to respond to the current increase and some of the underlying structural issues that have helped to contribute to the current problem and improve the service we provide to our members.

Rising to Meet the Challenge

While the challenges are great, we are better prepared today to address them than ever before. The re-organization of LACERA's internal structure along vertical business lines

of the Member Operations Group and the Business Services Group has increased synergy and allowed us to focus on underlying structural issues that drive call volumes and impact member services. Many of the member experience optimization projects discussed in the following presentation are examples of this synergy in action. Member Services identified call drivers and member problems and worked seamlessly with Benefits and Systems to implement plans to improve the experiences which we feel will reduce call volumes.

This synergy is helping us to implement quicker solutions wherever possible to help alleviate the current problem. The entire organization is aligned to focus on improving services for our members and understands the current service levels we are delivering are not acceptable. Our Quality Assurance Division has been conducting two classes simultaneously since the first of the year – something we previously had not been able to do and something that is not easy for them to do while still meeting quality audit expectations. Human Resources is focusing on expediting their recruiting processes to reduce our staff vacancy rate. Communications is working to identify vendors to help produce self-help videos quicker, while continuing to focus on updates to LACERA.com designed to help members navigate to the information they need more efficiently. Nearly every division in LACERA that touches member data, processes, or information are working together to tackle this challenge and improve services on an ongoing basis.

Noted and Reviewed:

Santos H. Kreimann
Chief Executive Officer

Member Services Contact Center

Pre-Pandemic Stats vs Post-Pandemic Stats

By JJ Popowich, Kelly Puga, Gerald Bucacao, Valerie Quiroz and Renee Copeland

Member Services Contact Center

Introduction

The Member Services Contact Center (MSCC) is one of two Call Centers that services LACERA members. The second contact center is Retiree HealthCare which provides comprehensive healthcare plans and resources for healthy living beyond retirement.

The Member Services Contact Center responds to all retirement inquiries from Active Members, Retired Members, Survivors, Beneficiaries, County Departments and third-party agencies.

The Member Services Call Center specialists provides retirement counseling, take death notifications, provide my LACERA portal support, provides monthly payroll information and many more LACERA related topics.

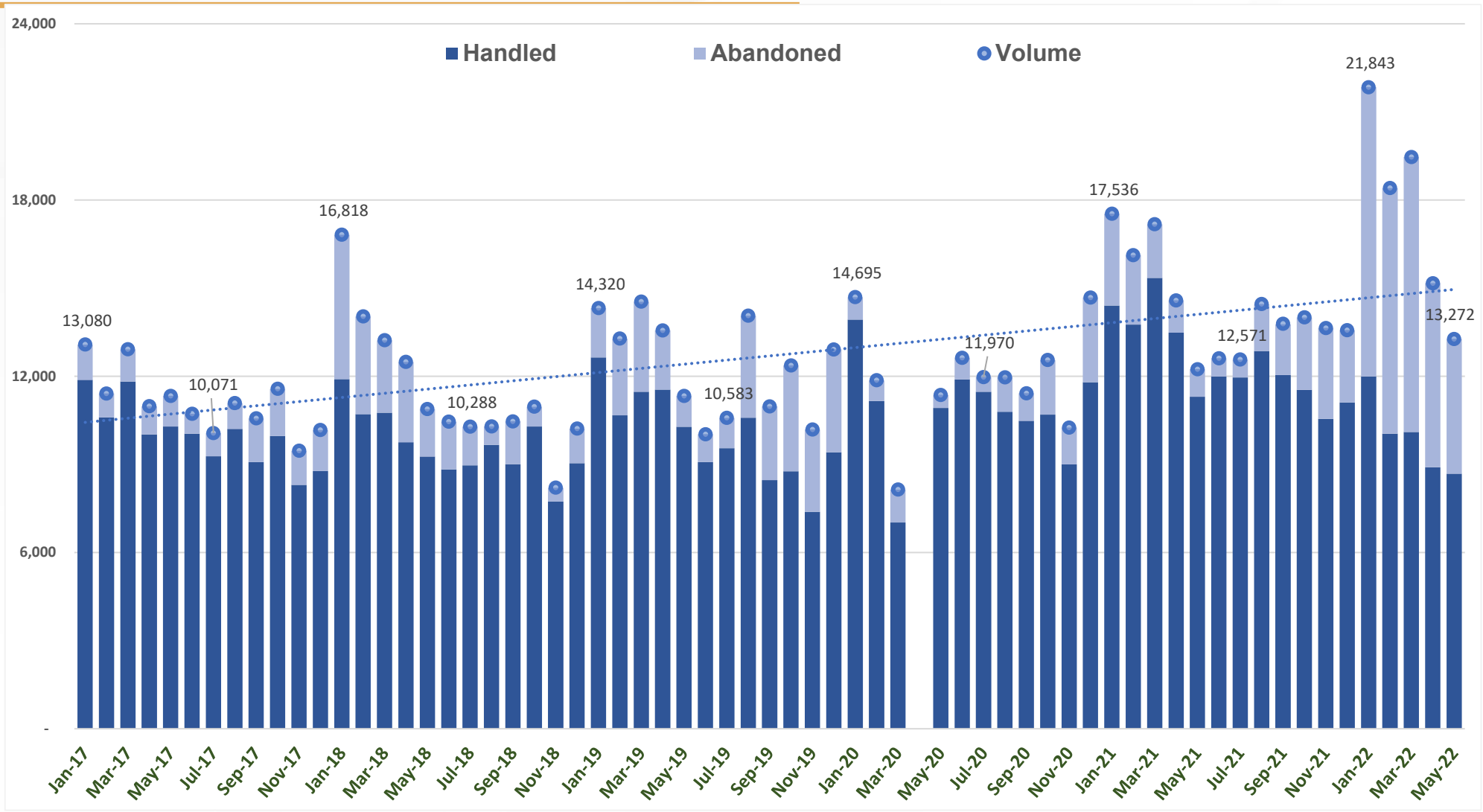
This presentation will focus on the Member Services Contact Center call volumes, trends and forecasting and the differences in working in-office and working remotely.

We will close with a look at how we are deploying the Four Pillars of Call Center Management to address and improve our service to members.

Member Services Contact Center

5-Year Call Volume, Handle & Abandon

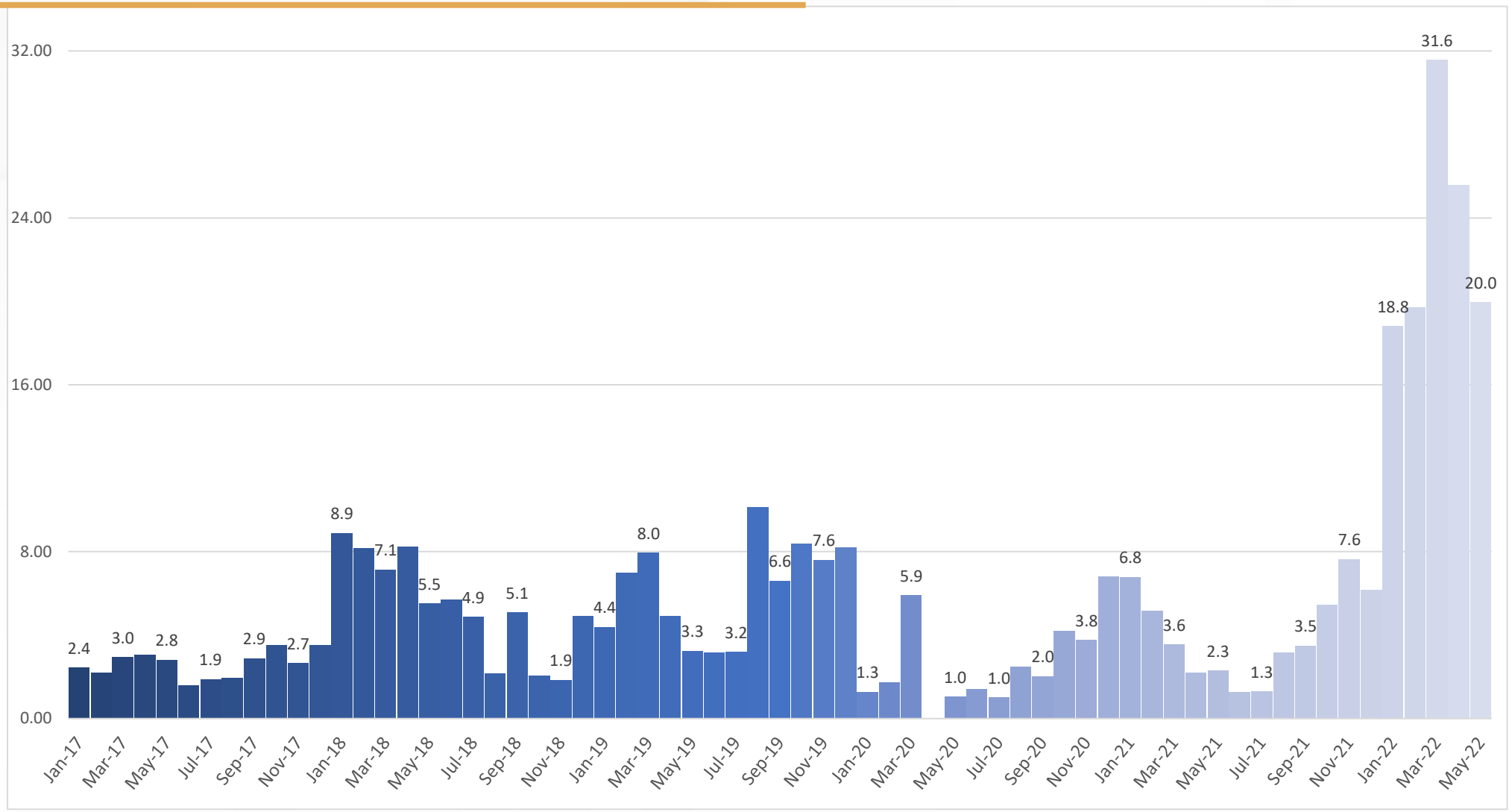
- Call Volume per Month
  - Pre-pandemic: 11,749
  - Pandemic: 14,459
  - 2022 YTD: 17,632
- 50% Increase since Pre-Pandemic
- 2022: Highest Call Volume Since we Started Tracking in 2006
- Abandoned Calls Per Month
  - Pre-pandemic: 1,718
  - Pandemic: 1,587
  - 2022 YTD: 7,686



Member Services Contact Center

5-Year Call Wait Times

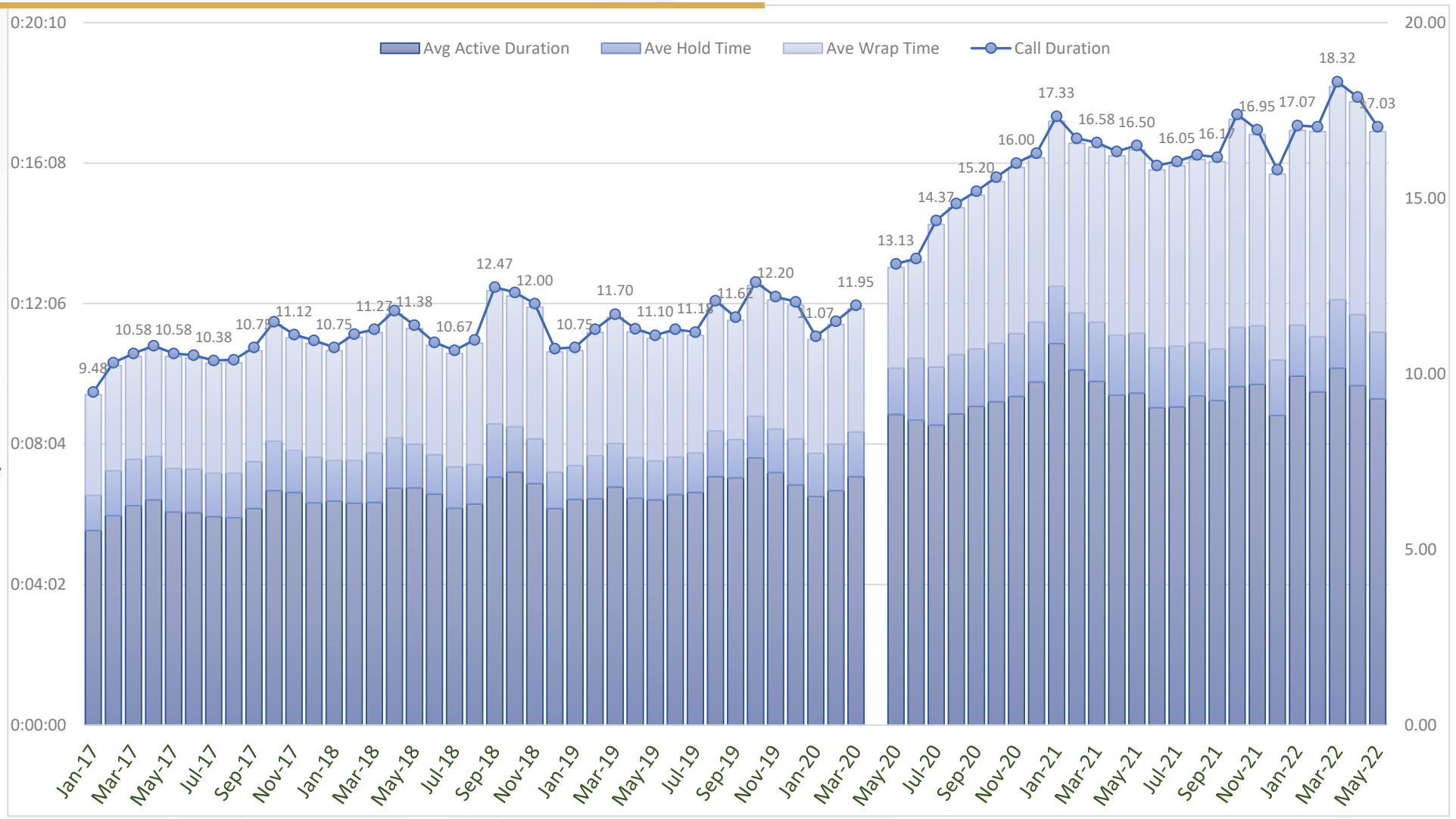
- **Call Center Shift starts at 7:00am and ends at 5:30pm**
- **Peak wait times from 11am-2pm during staff lunch schedules.**
- **Call Wait Times average:**
  - **Pre-pandemic: 4 minutes and 34 seconds**
  - **Pandemic: 3 minutes and 34 seconds.**
  - **2022 YTD: 23 minutes and 7 seconds**
- **Longest wait time in 2022: 1 hour 37 minutes and 52 seconds.**



Member Services Contact Center

5-Year Call Duration

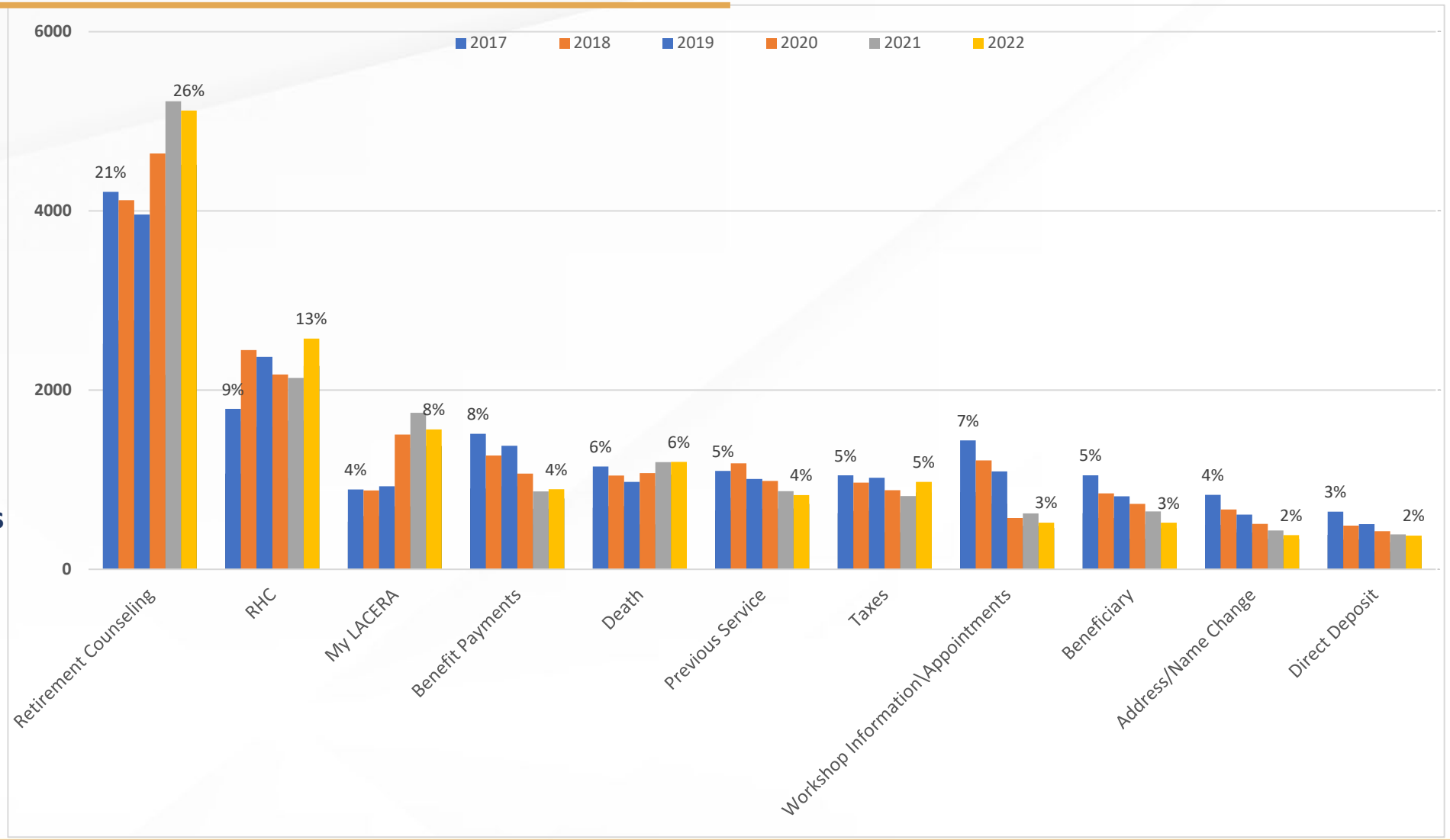
- **Average Call Duration**
  - **Pre-pandemic: 11 minutes and 13 seconds**
  - **Pandemic: 15 minutes and 50 seconds**
  - **2022 YTD: 17 minutes and 28 seconds**
- **Increase in retirement counseling:**
  - **Pre-Pandemic: 1 out of every 5 calls**
  - **Pandemic: 1 out of every 4 calls**
- **Retirement counseling calls range from 30 minutes to 2 hours.**



Member Services Contact Center

Top 11 Call Topics Account for 75% of Calls

- **Percentage of Retirement Counseling Calls:**
  - **Pre-Pandemic: 21%**
  - **Pandemic: 25%**
  - **2022 YTD: 26%**
- **Percentage of RHC Calls**
  - **Pre-Pandemic: 11%**
  - **Pandemic: 11%**
  - **2022 YTD: 13%**
- **Percentage of My LACERA Calls**
  - **Pre-Pandemic: 4%**
  - **Pandemic: 8%**
  - **2022 YTD: 8%**



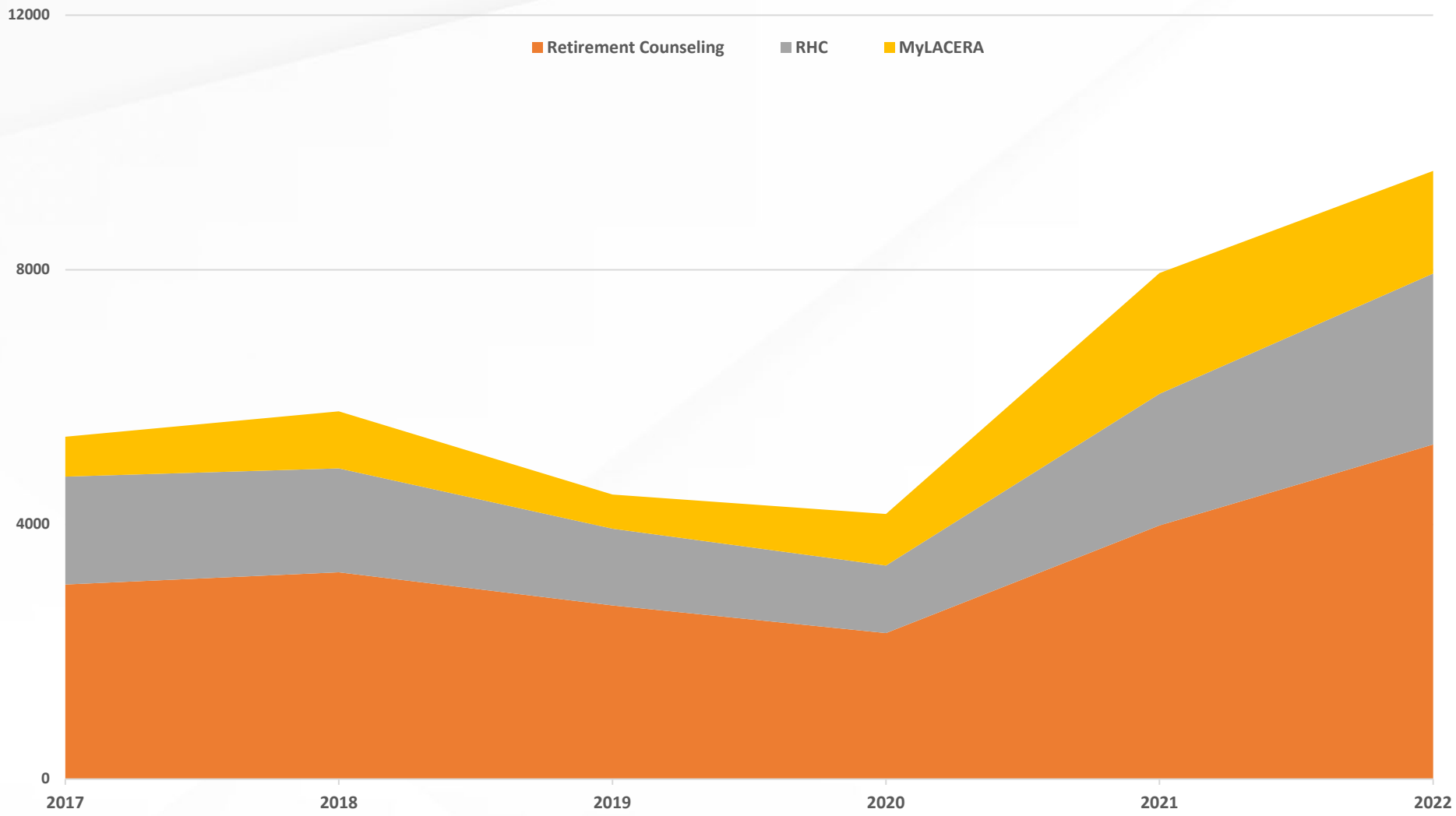
Member Services Contact Center

During ”March Madness” Nearly Half (47%) of Calls Driven by Three Call Topics

- **CALL VOLUME DRIVER INFO**

- **Three Topics Account for 47% of our calls and they are increasing year to year**

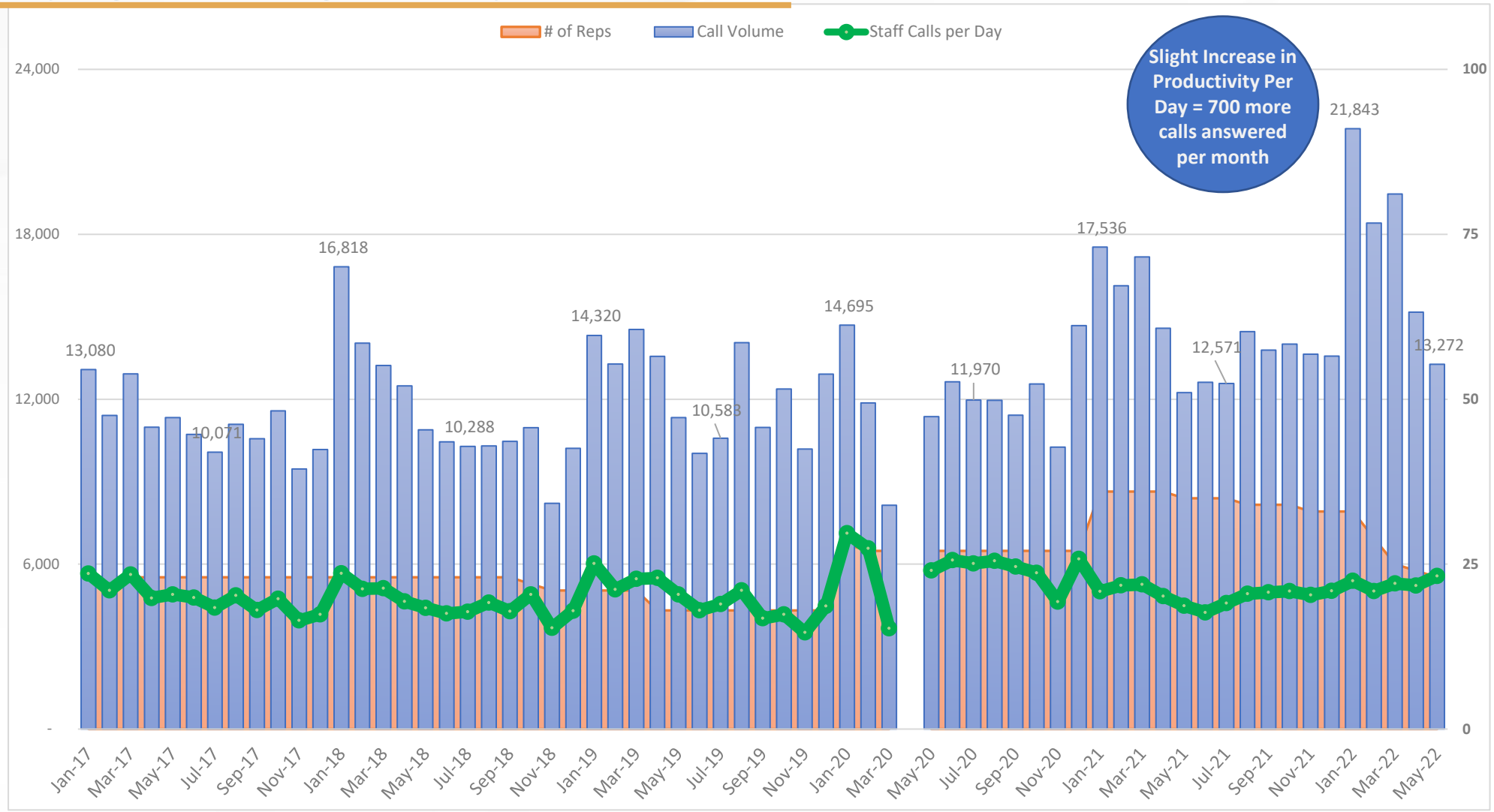
- **Retirement Counseling & My LACERA calls showing increased average duration**
  - **Counseling: 30 min to 1.5 hours**
  - **My LACERA: 15 min**
  - **Insurance: 10 min+**



Member Services Contact Center

Staff Productivity Slightly Higher Working Remotely

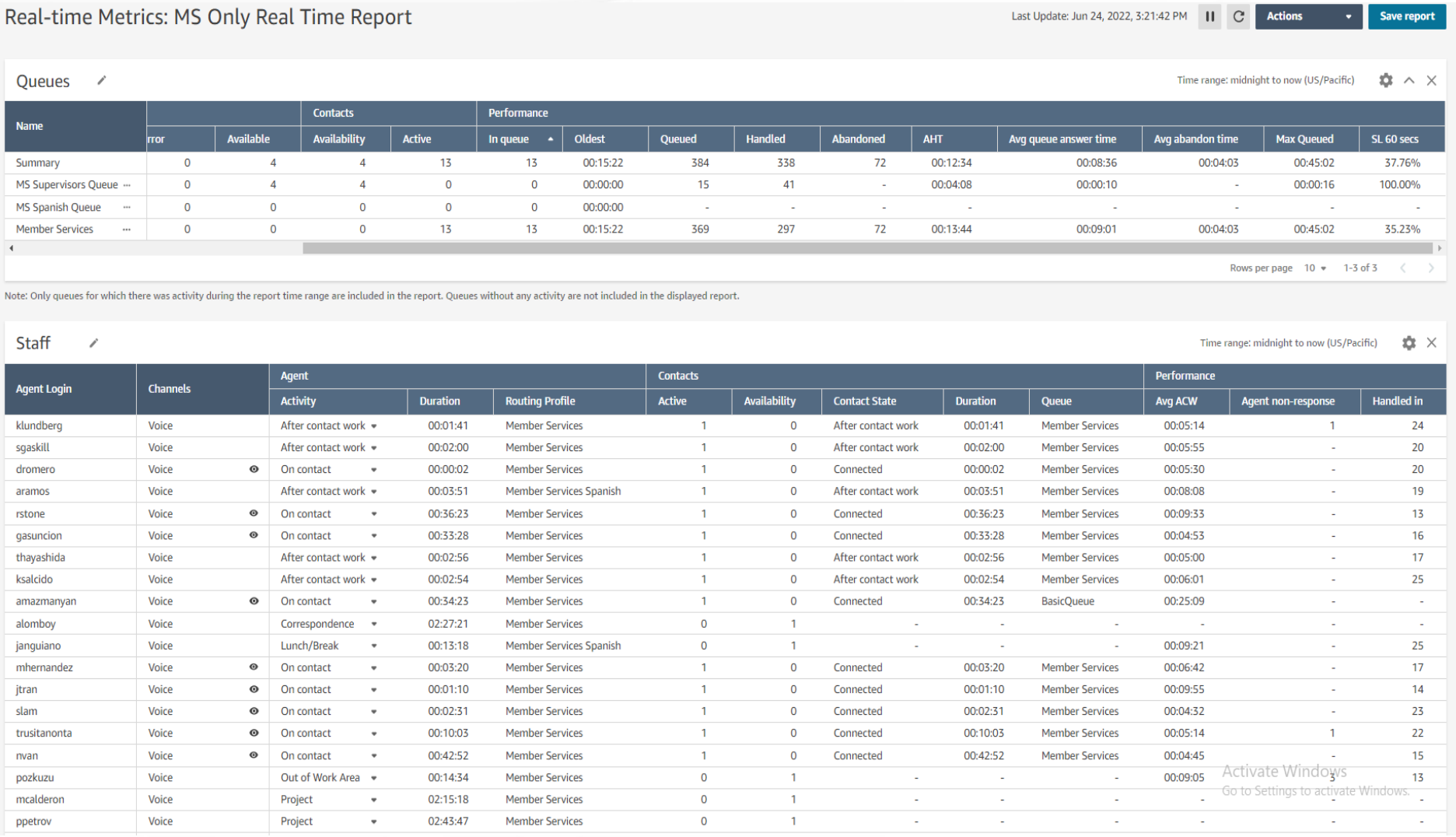
- **Actual Staff Count Per Day**
  - **Pre-Pandemic: 22**
  - **Pandemic 32**
  - **2022 YTD: 25**
  - **Scheduled to drop to 19 by August 1**
- **Staff Productivity (Calls Per Day):**
  - **Pre-Pandemic: 19.9 calls**
  - **Pandemic: 21.9 calls**
  - **2022 YTD: 22.1 calls**



Member Services Contact Center

Amazon Connect – Performance & Service is Managed Proactively

- **Agent activity is monitored throughout the shift and supervisors can determine if a staff is On contact, on After Call Work, Hold, Break, etc.**
- **Supervisors are monitoring activity constantly per day adjusting trainings, meetings and breaks real time depending on call volume and staff availability.**
- **Employee engagement activities continues to be a focus including:**
  - **Daily Check in Huddles**
  - **Monthly staff meetings**
  - **One on one coaching**
  - **Ad-hoc meetings and huddles**



Real-time Metrics: MS Only Real Time Report

Last Update: Jun 24, 2022, 3:21:42 PM | Actions | Save report

Queues

Time range: midnight to now (US/Pacific)

Name			Contacts		Performance									
	rror	Available	Availability	Active	In queue	Oldest	Queued	Handled	Abandoned	AHT	Avg queue answer time	Avg abandon time	Max Queued	SL 60 secs
Summary	0	4	4	13	13	00:15:22	384	338	72	00:12:34	00:08:36	00:04:03	00:45:02	37.76%
MS Supervisors Queue	0	4	4	0	0	00:00:00	15	41	-	00:04:08	00:00:10	-	00:00:16	100.00%
MS Spanish Queue	0	0	0	0	0	00:00:00	-	-	-	-	-	-	-	-
Member Services	0	0	0	13	13	00:15:22	369	297	72	00:13:44	00:09:01	00:04:03	00:45:02	35.23%

Rows per page 10 | 1-3 of 3

Note: Only queues for which there was activity during the report time range are included in the report. Queues without any activity are not included in the displayed report.

Staff

Time range: midnight to now (US/Pacific)

Agent Login	Channels	Agent			Contacts					Performance		
		Activity	Duration	Routing Profile	Active	Availability	Contact State	Duration	Queue	Avg ACW	Agent non-response	Handled in
klundberg	Voice	After contact work	00:01:41	Member Services	1	0	After contact work	00:01:41	Member Services	00:05:14	1	24
sgaskill	Voice	After contact work	00:02:00	Member Services	1	0	After contact work	00:02:00	Member Services	00:05:55	-	20
dromero	Voice	On contact	00:00:02	Member Services	1	0	Connected	00:00:02	Member Services	00:05:30	-	20
aramos	Voice	After contact work	00:03:51	Member Services Spanish	1	0	After contact work	00:03:51	Member Services	00:08:08	-	19
rstone	Voice	On contact	00:36:23	Member Services	1	0	Connected	00:36:23	Member Services	00:09:33	-	13
gasuncion	Voice	On contact	00:33:28	Member Services	1	0	Connected	00:33:28	Member Services	00:04:53	-	16
thayashida	Voice	After contact work	00:02:56	Member Services	1	0	After contact work	00:02:56	Member Services	00:05:00	-	17
ksalcido	Voice	After contact work	00:02:54	Member Services	1	0	After contact work	00:02:54	Member Services	00:06:01	-	25
amazmanyan	Voice	On contact	00:34:23	Member Services	1	0	Connected	00:34:23	BasicQueue	00:25:09	-	-
alomboy	Voice	Correspondence	02:27:21	Member Services	0	1	-	-	-	-	-	-
janguiano	Voice	Lunch/Break	00:13:18	Member Services Spanish	0	1	-	-	-	00:09:21	-	25
mhernandez	Voice	On contact	00:03:20	Member Services	1	0	Connected	00:03:20	Member Services	00:06:42	-	17
jtran	Voice	On contact	00:01:10	Member Services	1	0	Connected	00:01:10	Member Services	00:09:55	-	14
slam	Voice	On contact	00:02:31	Member Services	1	0	Connected	00:02:31	Member Services	00:04:32	-	23
trusitanonta	Voice	On contact	00:10:03	Member Services	1	0	Connected	00:10:03	Member Services	00:05:14	1	22
nvan	Voice	On contact	00:42:52	Member Services	1	0	Connected	00:42:52	Member Services	00:04:45	-	15
pozkuzu	Voice	Out of Work Area	00:14:34	Member Services	0	1	-	-	-	00:09:05	-	13
mcalderon	Voice	Project	02:15:18	Member Services	0	1	-	-	-	-	-	-
ppetrov	Voice	Project	02:43:47	Member Services	0	1	-	-	-	-	-	-

Member Services Contact Center

5-Year Occupancy

- **Occupancy:**
  - **Pre-Pandemic: 75.2%**
  - **Pandemic: 79.9%**
  - **2022 YTD: 98.2%**

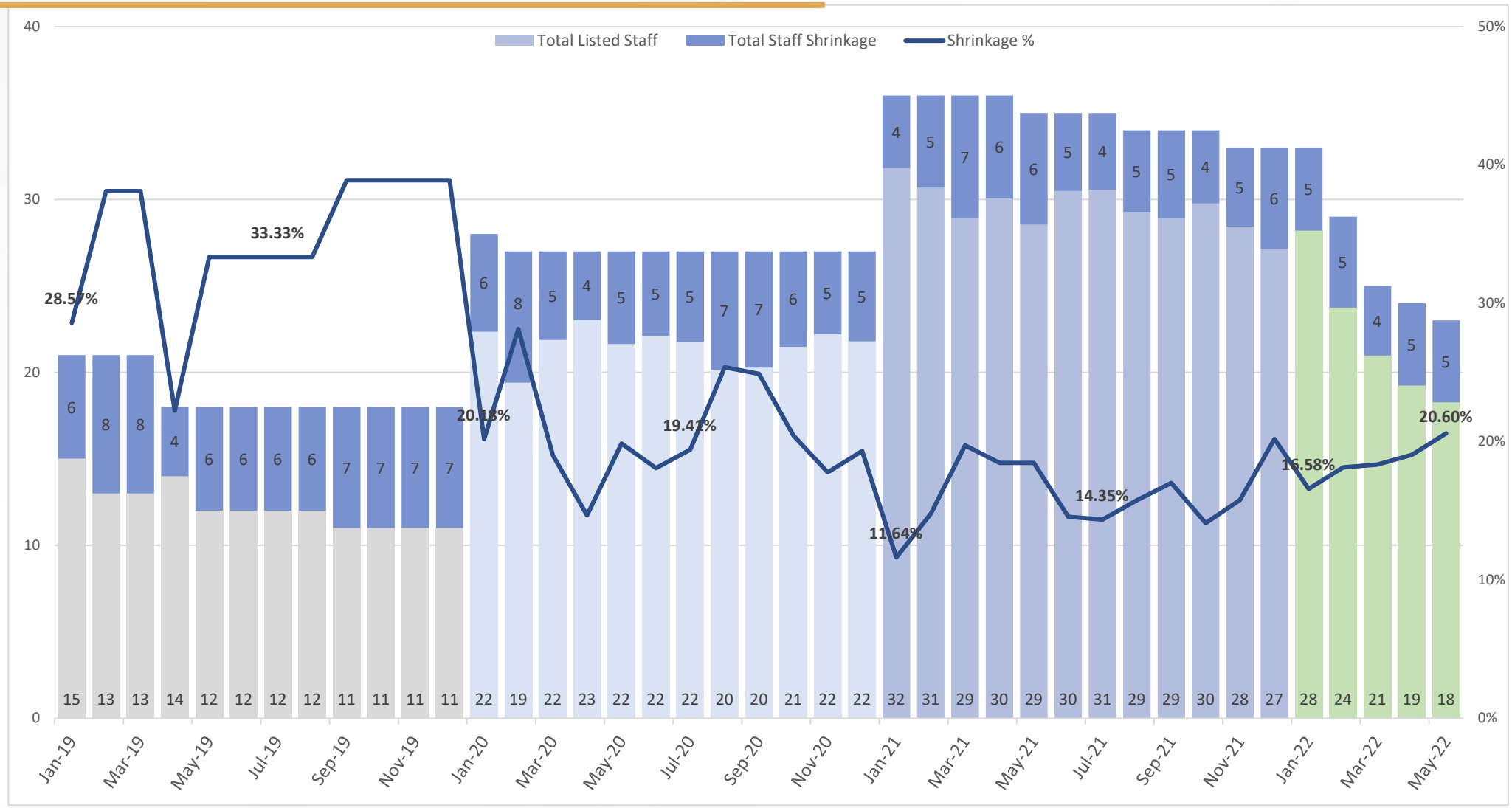
- **Ideally, we should be operating within 65% - 85% Occupancy or from 4 hours and 53 minutes to 6 hours and 22 minutes a day directly interacting with members**

- **Current occupancy averages in 2022 of 98.2% equivalent to staff talking to members 7 hours and 10 minutes a day.**

Member Services Contact Center

3-Year Shrinkage

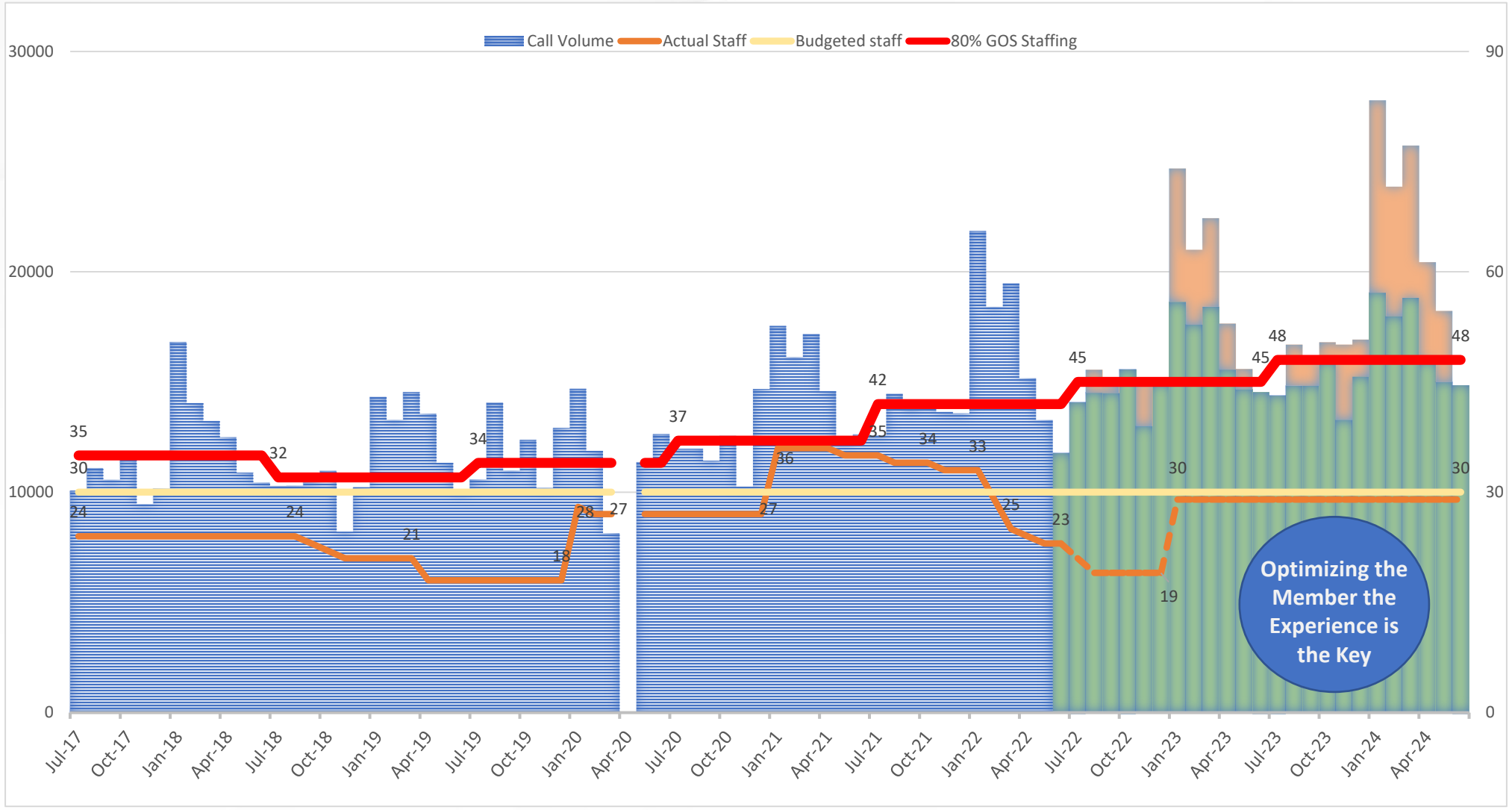
- **Shrinkage (Absenteeism):**
  - **Pre-Pandemic: 32.2%,**
  - **Pandemic: 18.0%**
  - **2022 YTD: 18.5%**
- **July 2022 Staff is currently at 21 FTEs**
- **Annualized attrition for 2022 year-to-date is at 44.7% vs previous 4 years average of 10.3%**



MS Contact Center

2-Year Forecast Information

- **Average Call Growth Per Year:**
  - **Last 10 Years: 2.2% per year**
  - **Last 5 Years: 5.0% per year**
  - **Last 3 Years: 9.6% per year**
- **Forecast at 5%:**
  - **FY-2022: 191,873**
  - **FY-2023: 201,466**
- **Budgeted Staff Answering Calls: 30**
- **Current Staff: 21 reducing to 19 by August 1**
- **Target staff to hit 80% GOS projected to be at 45 in 2022 and 48 in 2023.**



Member Services Contact Center

Applying the Four Pillars of Call Center Management: Current Efforts

Correct Staffing Models

- Two Core Benefit Classes: 11 of 23 trainees allocated to Call Center
- Remainder go to Member Care Unit and Benefits – which will improve service and hopefully reduce call volume

Performance Management

- Continued focus on managing and supporting staff
- Continued focus on quality – meeting and exceeding our quality KPI

Process Improvement

- MS Teams Chat: Immediate communication between staff and supervisors – decreases call duration and improves service

Member Experience Optimization

- Revised training protocols for RBS staff assigned to Retiree Healthcare – no longer required to go through CORE Benefits Training
- Re-Engineering Death & Legal Claim Process: Reduces claim form issuance time and improves processing time for returned forms – reduces follow up calls and speeds claim resolution
- Multi-Factor Authorization (MFA): Improves My LACERA login experience – expected to reduce password reset calls
- LACERA.com Enhancements: Revising document upload instructions, developing how to videos for registering and logging into My LACERA, adding sample forms for Retiree Healthcare (to reduce calls for assistance filling out enrollment forms)
- Debit Card RFP: Future improvements to reduce calls for lost checks, replacement checks, etc.

Member Services Contact Center

Applying the Four Pillars of Call Center Management: Future Plans & Possibilities

Correct Staffing Models

- Continual Call Center Staff Recruitment: Begin recruitment for the next class with a tentative start date in late Fall 2022
- Discussing plans to allow over-hiring to ensure we have staff to fill vacancies quicker

Performance Management

- Continued focus on managing and supporting staff and quality control

Process Improvement

- Case Management: Enhanced information and status available to Specialists – reduces call duration, improves services
- AI Assisted Calls (New Call Center Phone System): Provide real-time suggestions and advice to Specialist assisting members and possible automated assistance to members reducing call volume

Member Experience Optimization

- Pre-Call Validation (New Call Center Phone System): Pre-call member identification in the IVR – allows call personalization and reduces call duration
- Hold Your Place in Line/Scheduled Call Backs: Allows member to end call and receive a call when its their turn in line
- LACERA.com Enhancements: Adding additional how-to videos, possible AI assisted chat for common issues and requests
- New Member Sworn Statement Process: Require new members register with My LACERA to complete their Sworn Statement online – establishes an electronic relationship with members from the start – bolstering acceptance of self-service and web-based interactions which will reduce calls
- Consider expanding call center hours to 8 PM and offer Saturday service to allow active members more flexibility

Member Services Contact Center

In Summary

What does the data show?

- Continual trend of higher call volumes, with an unprecedented spike beginning in 2022
- Call volume driven by four main categories: Retirement Counseling, Insurance, Benefit Payments, and My LACERA
- Largest call driver is Retirement Counseling – which is also the call with the highest duration.
- Continual trend of higher duration calls

What does the data show regarding productivity?

- Staff are taking more calls per staff member today, then ever before
- Occupancy is off the charts – showing staff are working non-stop to help members
- Shrinkage is way down – meaning staff are engaged and working hard day after day
- Call Center staff are working more productively remotely – than in the office

Continuing to focus on the Four Pillars of Call Center Management to improve service & reduce call wait times?

- Consistently recruit and keep a consistent pipeline of incoming staff to replace outgoing staff
- Implement improvement projects planned to optimize the member experience
- Continue focusing on call drivers, implementing process improvements wherever possible
- Take advantage of technological innovation to improve service, offering enhanced self-service, and reducing call volume

Member Services Contact Center

Questions?

kpuga@lacera.com | 626-564-6000

Appendix

Member Services Contact Center

Call Center Terminology

Occupancy

- Percentage of time spent assisting a member versus being logged into the queue. It is a productivity measure and should not exceed 85%

Shrinkage

- A measure of how much time a staff member is not logged into the queue and assisting members. Generally consisting of absenteeism, tardiness, FMLA absences, training, coaching, other work-related activities.

Average Speed of Answer (ASA)

- How quickly (in seconds) a call is answered. Sometimes referred to as Call Wait Time

Call Duration (Average Handle Time or AHT)

- The total number of minutes staff takes to handle a member's call. It includes talk time, hold time, and after call wrap time associated with that call.

Grade of Service (GOS)

- The percentage of calls answered within a set period. Also known as service levels.

Member Services Contact Center

Key Performance Indicators (KPI)

Agent Occupancy	Call Monitoring Score	Grade of Service (GOS)	Call Center Survey Score
• This metric measures how much direct time is spent assisting members.	• Call Monitoring is a way for us to see how well we are taking care of our members based on objective evaluations based on specific measurable categories.	• Grade of Service essentially measures how fast we answer a call. It is a measurement of how many calls we answer within a set amount of time represented as a percentage.	• Call Center Survey Score - Direct member feedback is critical to measuring our success. The survey overall score was chosen because it is the only direct member feedback we receive from our members.
• Occupancy Target is 65%.	• Call Monitoring Score Target is 95%.	• GOS Target is 80% of calls answered in 60 seconds.	• Survey Target is 90%

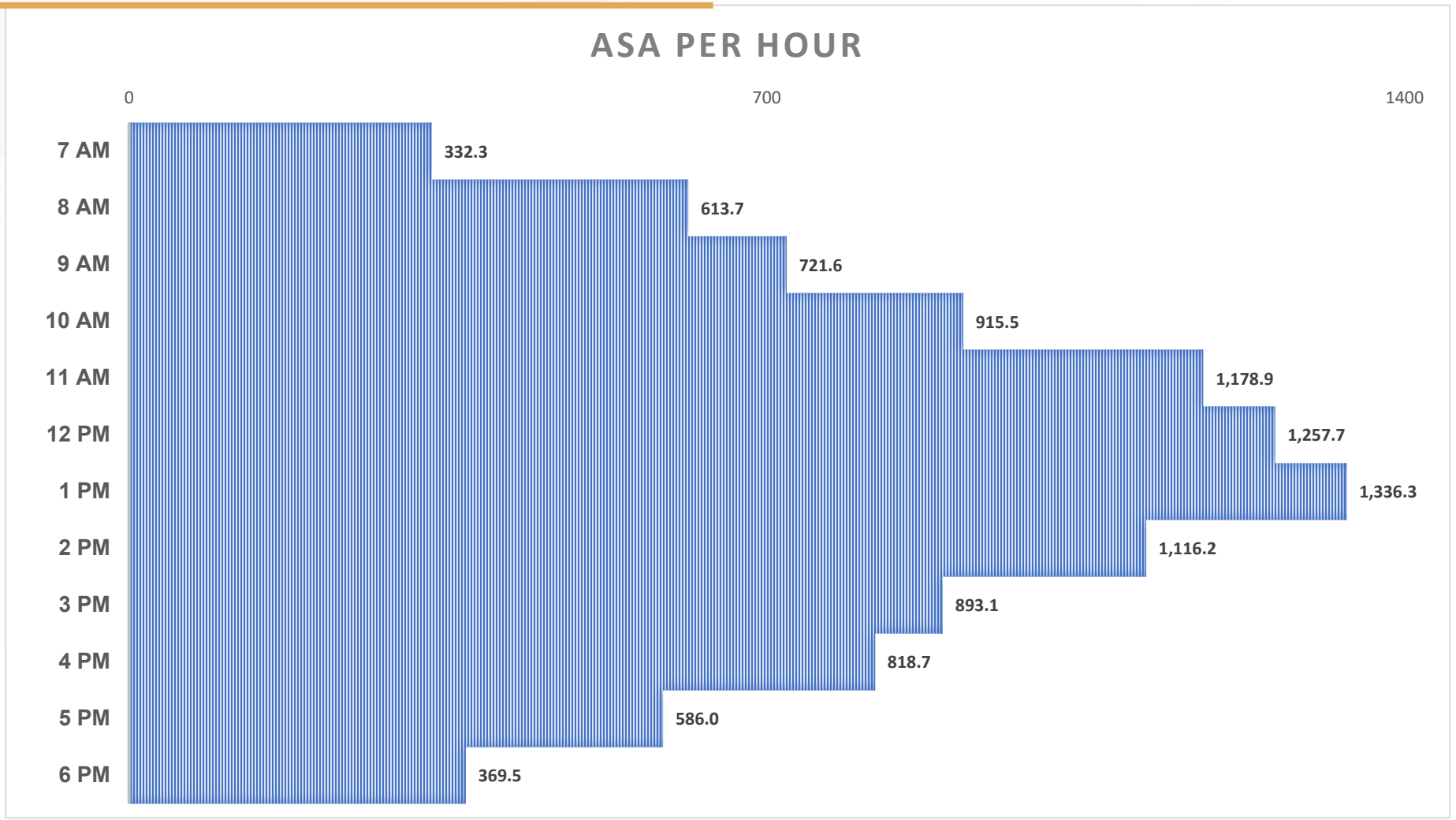
Appendix

Hourly Call Wait Times

We included this as an appendix item to demonstrate another factor that impacts wait times that we currently cannot do anything about.

Most calls come in between 10 am and 4 pm, which coincides with the staff break and lunch schedules.

To compensate we try to vary staff start times, but because the call center operating hours are compressed, we cannot vary their hours enough to spread out the impact of multiple staff going on break or lunch at the same time.



* Data includes wait times in May and early June 2022, although is also indicative of the pattern of call wait times throughout the year.

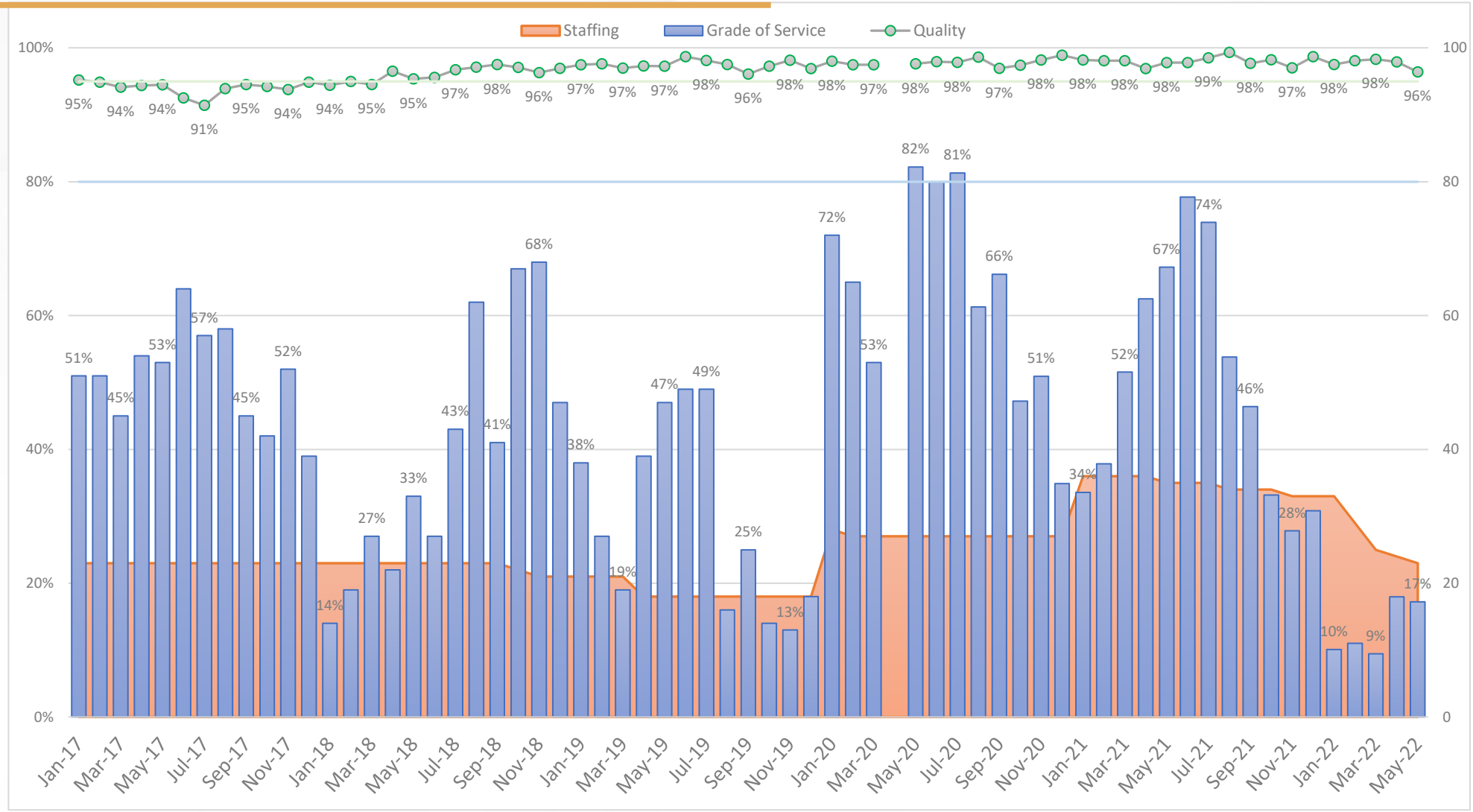
Appendix

5-Year Staffing, Grade of Service and Quality

We included this as an appendix item to demonstrate performance over the past 5 years

- Quality performance has maintained above 95% target.
  - Pre-pandemic - 95.99%
  - Pandemic to now - 97.92%

- Service level
  - Pre-pandemic - 42%
  - Pandemic to now - 47%



LACERA

June 29, 2022

FOR INFORMATION ONLY

TO: Each Trustee,
Board of Retirement
Board of Investments

FROM: Luis A. Lugo
Deputy Chief Executive Officer

FOR: July 6, 2022 Board of Retirement Meeting
July 13, 2022 Board of Investments Meeting

SUBJECT: SEIU Local 850/851 Meeting Held on May 25, 2022

During the June 13, 2022 Joint Board meeting, the Joint Boards directed staff to investigate remarks made during Public Comment. More specifically, union representatives made statements that included alleged inappropriate conduct by a LACERA management staffer during an SEIU sponsored meeting held on May 25, 2022, at LACERA's main office in Pasadena.

On May 25, 2022, I received an email communication from the leadership team at SEIU 850/851 requesting to meet "regarding LACERA falsely accusing SEIU of violating Memorandum of Understanding." The issue in question was whether SEIU's representative followed proper procedures in scheduling an onsite luncheon for their membership within LACERA's offices. I promptly responded with an email that same day to coordinate a meeting between LACERA management and SEIU 850/851 leadership.

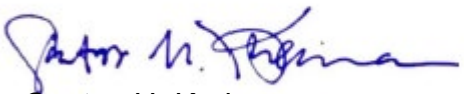
A virtual meeting was held on June 2, 2022, with LACERA management and SEIU 850/851 leadership to discuss issues and alleged conduct from a LACERA staff member. During the meeting, it was determined that the incident was a mutual misunderstanding and miscommunication between an SEIU representatives and LACERA's Human Resource Division regarding the process used for scheduling meeting space at our headquarters building. Also, the union representatives wrote a letter and sent an email to LACERA's Chief Executive Officer and Deputy Chief Executive Officer on June 2, 2022, alleging a LACERA staff member was videotaping their meeting. This allegation was determined to be unfounded. Instead, at the time and later confirmed, the LACERA staff member was logged into a regular virtual LACERA all-staff Brown Bag meeting using their mobile device.

During the June 2nd meeting, we addressed with our labor partners the conduct allegations detailed in the letter and protocols for scheduling meeting space in the future. Both LACERA and SEIU 850/851 mutually agreed upon a process moving forward that would allow for a back-up point of contact, if needed. The meeting was productive and LACERA believed the issue was resolved, which is the reason management did not bring this to the attention of the Trustees. In fact, SEIU representatives successfully used the agreed upon scheduling protocol the following day to secure meeting space.

The public comments made to the Joint Boards on June 13, 2022, were unexpected, as we considered the issue properly addressed and timely resolved following our June 2, 2022, meeting with SEIU 850/851 leadership.

We are committed to moving forward and working collaboratively in a collegial manner by establishing regularly scheduled joint labor and management meetings with union representatives. As always, management will continue to foster a positive and productive work environment for all represented and non-represented staff at LACERA.

Noted and Reviewed:



Santos H. Kreimann
Chief Executive Officer

SK:ll

LACERA

FOR INFORMATION ONLY

June 26, 2022

TO: Each Trustee
Board of Retirement
Board of Investments

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: July 6, 2022 Board of Retirement Meeting
July 13, 2022 Board of Investments Meeting

SUBJECT: **Monthly Status Report on Legislation**

Attached is the monthly report on the status of legislation that staff is monitoring or on which LACERA has adopted a position. Also included is a copy of a recent support letter.

Reviewed and Approved:

Steven P. Rice, Chief Counsel

Attachments
LACERA Legislative Report Index
LACERA Legislative Report
AB 1971 support letter

cc: Santos H. Kreimann
Luis Lugo
JJ Popowich
Laura Guglielmo
Steven P. Rice
Jon Grabel
Scott Zdrazil
Tony Roda, Williams & Jensen
Shari McHugh, McHugh Koepke & Associates
Naomi Padron, McHugh Koepke & Associates

LACERA Legislative Report
2021-22 Legislative Session
Status as of June 26, 2022

PUBLIC RETIREMENT

CA AB 551

AUTHOR: Rodriguez [D]
TITLE: Disability Retirement: Covid-19: Presumption
INTRODUCED: 02/10/2021
LAST AMEND: 05/09/2022
DISPOSITION: Pending
SUMMARY:

Establishes a disability retirement presumption that is applicable to the members of various public employee retirement systems who are employed in certain firefighter, public safety officer, and health care job classifications, among others, who test positive for COVID-19, as specified. Extends the operation of the provisions until specified date.

STATUS:

06/21/2022 In SENATE. Read second time. To third reading.

CA AB 826

AUTHOR: Irwin [D]
TITLE: Compensation and Compensation Earnable
INTRODUCED: 02/16/2021
LAST AMEND: 08/31/2021
DISPOSITION: Pending
SUMMARY:

Relates to the bill, which would apply only in Ventura County. Provides that compensation and compensation earnable include flexible benefits plan allowances paid by a county or a district on behalf of its employees as part of a cafeteria plan, as specified, if certain requirements are met.

STATUS:

09/08/2021 In SENATE. From third reading. To Inactive File.
BOR_Position: Watch *09/01/2021*
IBLC_Recommendation: Watch *08/12/2021*
Staff_Recommendation: Watch

CA AB 1667

AUTHOR: Cooper [D]
TITLE: State Teachers' Retirement System: Administration
INTRODUCED: 01/19/2022
LAST AMEND: 05/19/2022
DISPOSITION: Pending
SUMMARY:

Defines exclusive representative for purposes of State Teachers' Retirement System. Requires the public agency to provide, as specified, the board and the exclusive representative a list of the names of any member affected by the audit not included in the board' s list.

STATUS:

06/22/2022 From SENATE Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT: Do pass to Committee on JUDICIARY. (4-0)

CA AB 1722

AUTHOR: Cooper [D]
TITLE: Public Employees' Retirement: Safety Members
INTRODUCED: 01/27/2022
DISPOSITION: Pending
SUMMARY:

Relates to the Public Employees' Retirement Law which, until January 1, 2023, provides a state safety member of the Public Employees' Retirement System who retires for industrial disability a retirement benefit equal to the greatest amount resulting from 3 possible calculations. Deletes the termination of these provisions on January 1, 2023, thereby making them operative in perpetuity.

STATUS:

06/01/2022	To SENATE Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT.

CA AB 1824

AUTHOR: Public Employment and Retirement Cmt
TITLE: Public Employees' Retirement
INTRODUCED: 02/07/2022
LAST AMEND: 05/25/2022
DISPOSITION: Pending

SUMMARY:

Establishes the State Teachers' Retirement System and creates the Defined Benefit Program of the State Teachers' Retirement Plan, which provides a defined benefit to members of the program, based on final compensation, creditable service, and age at retirement, subject to certain variations.

STATUS:

05/25/2022	From SENATE Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT with author's amendments.
05/25/2022	In SENATE. Read second time and amended. Re-referred to Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT.

Comments:

Omnibus bill containing SACRS 2022 legislative proposals.

BOR_Position: Support *05/05/2022*
IBLC_Recommendation: Support *04/06/2022*
Staff_Recommendation: Support

CA AB 1971

AUTHOR: Cooper [D]
TITLE: County Employees Retirement Law of 1937
INTRODUCED: 02/10/2022
LAST AMEND: 06/09/2022
DISPOSITION: Pending

SUMMARY:

Authorizes a person who is retired and receiving a retirement benefit from a county system to serve without reinstatement for service on a part-time board or commission operating under a participating agency of the same county retirement system. Prohibits a retired person acting in this capacity from acquiring benefits, service credit, or retirement rights with respect to the service and would prescribe limits on the salary or stipend for service with the board or commission.

STATUS:

06/09/2022	From SENATE Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT with author's amendments.
06/09/2022	In SENATE. Read second time and amended. Re-referred to Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT.

Comments:

Omnibus bill containing SACRS 2022 legislative proposals.

BOR_Position: Support *06/01/2022*

IBLC_Recommendation: Support *05/05/2022*
Staff_Recommendation: Support

CA AB 2443

AUTHOR: Cooley [D]
TITLE: Public Employees' Retirement: Federal Law
INTRODUCED: 02/17/2022
LAST AMEND: 06/22/2022
DISPOSITION: Pending
SUMMARY:

Prescribes the method by which benefits are to be reduced when federal law requires aggregation of benefits from different plans maintained by the same employer and federal limits on benefits are reached.

STATUS:

06/22/2022 From SENATE Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT with author's amendments.
06/22/2022 In SENATE. Read second time and amended. Re-referred to Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT.

CA AB 2493

AUTHOR: Chen [R]
TITLE: County Employees' Retirement Disallowed Compensation
INTRODUCED: 02/17/2022
LAST AMEND: 04/05/2022
DISPOSITION: Pending
SUMMARY:

Authorizes a county retirement system to adjust retirement payments based on disallowed compensation for sworn peace officers and firefighters of that system. Provides that if the retirement system determines that the compensation reported for a sworn peace officer or firefighter of the system is disallowed compensation, as defined, the system would require the county employer or agency to discontinue reporting the disallowed compensation.

STATUS:

06/22/2022 From SENATE Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT: Do pass to Committee on JUDICIARY. (4-0)
IBLC_Recommendation: Neutral *06/01/2022*
Staff_Recommendation: Neutral

US HR 2954

SPONSOR: Neal [D]
TITLE: Strong Retirement
INTRODUCED: 05/04/2021
LAST AMEND: 03/29/2022
DISPOSITION: Pending
SUMMARY:

Secures a Strong Retirement Act of 2021.

STATUS:

03/30/2022 In SENATE. Read second time.
03/30/2022 To SENATE Committee on FINANCE.

Comments:

Would gradually raise the age for mandatory distributions to age 75 by 2032.

US HR 6241

SPONSOR: Thompson M [D]
TITLE: Use of Retirement Funds

INTRODUCED: 12/09/2021
DISPOSITION: Pending
SUMMARY:

Amends the Internal Revenue Code of 1986 to provide for rules for the use of retirement funds in connection with federally declared disasters.

STATUS:

12/09/2021 INTRODUCED.
12/09/2021 To HOUSE Committee on WAYS AND MEANS.

US S 1703

SPONSOR: Grassley [R]
TITLE: Retirement Plan Administration
INTRODUCED: 05/19/2021
DISPOSITION: Pending
SUMMARY:

Amends the Internal Revenue Code of 1986 to increase retirement savings, to improve retirement plan administration.

STATUS:

05/19/2021 INTRODUCED.
05/19/2021 In SENATE. Read second time.
05/19/2021 To SENATE Committee on FINANCE.

US S 1770

SPONSOR: Cardin [D]
TITLE: Retirement Provisions
INTRODUCED: 05/20/2021
DISPOSITION: Pending
SUMMARY:

Amends the Internal Revenue Code of 1986 to reform retirement provisions.

STATUS:

05/20/2021 INTRODUCED.
05/20/2021 In SENATE. Read second time.
05/20/2021 To SENATE Committee on FINANCE.

PUBLIC INVESTMENT

CA SB 1173

AUTHOR: Gonzalez [D]
TITLE: Public Retirement Systems: Fossil Fuels: Divestment
INTRODUCED: 02/17/2022
LAST AMEND: 04/21/2022
DISPOSITION: Pending
SUMMARY:

Prohibits the boards of the Public Employees' Retirement System and the State Teachers' Retirement System from making new investments or renewing existing investments of public employee retirement funds in a fossil fuel company. Suspends the above described liquidation provision upon a good faith determination by the board that certain conditions materially impact normal market mechanisms for pricing assets.

STATUS:

06/02/2022 To ASSEMBLY Committees on PUBLIC EMPLOYMENT AND RETIREMENT and JUDICIARY.

CA SB 1328

AUTHOR: McGuire [D]
TITLE: Investments and Contracts: Russia and Belarus
INTRODUCED: 02/18/2022
LAST AMEND: 05/19/2022

DISPOSITION: Pending

SUMMARY:

Prohibits the boards of specified state and local public retirement systems from making additional or new investments in prohibited companies, as defined, domiciled in Russia or Belarus, as defined, companies that the United States government has designated as complicit in the aggressor countries', as defined, war in Ukraine, or companies that supply military equipment to the aggressor countries, and to liquidate the investments of the board in those companies, as specified.

STATUS:

06/09/2022 To ASSEMBLY Committees on PUBLIC EMPLOYMENT AND RETIREMENT and ACCOUNTABILITY AND ADMINISTRATIVE REVIEW.

WORKERS COMPENSATION

CA AB 334

AUTHOR: Mullin [D]

TITLE: Workers Compensation: Skin Cancer

INTRODUCED: 01/27/2021

DISPOSITION: Pending

SUMMARY:

Relates to existing law which provides that skin cancer developing in active lifeguards, for purposes of workers' compensation, is presumed to arise out of and in the course of employment, unless the presumption is rebutted. Expands the scope of this provision to certain peace officers of the Department of Fish and Wildlife and the Department of Parks and Recreation.

STATUS:

09/10/2021 In SENATE. From third reading. To Inactive File.

CA AB 1751

AUTHOR: Daly [D]

TITLE: Workers' Compensation: COVID-19: Critical Workers

INTRODUCED: 02/01/2022

DISPOSITION: Pending

SUMMARY:

Extends specified workers' compensation provisions relating to COVID-19 until January 1, 2025.

STATUS:

06/08/2022 To SENATE Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT.

CA SB 213

AUTHOR: Cortese [D]

TITLE: Workers Compensation: Hospital Employees

INTRODUCED: 01/12/2021

LAST AMEND: 05/05/2022

DISPOSITION: Pending

SUMMARY:

Defines injury for a hospital employee who provides direct patient care in an acute care hospital, to include infectious diseases, cancer, musculoskeletal injuries, post traumatic stress disorder, and respiratory diseases. Includes the novel coronavirus 2019, among other conditions, in the definitions of infectious and respiratory diseases. Creates rebuttable presumptions that these injuries that develop or manifest in a hospital employee who provides direct patient care in an acute care hospital.

STATUS:

06/22/2022 In ASSEMBLY Committee on INSURANCE: Heard, remains in Committee.

CA SB 284

AUTHOR: Stern [D]
TITLE: Workers' Compensation: Firefighters and Peace Officers
INTRODUCED: 02/01/2021
LAST AMEND: 08/30/2021
DISPOSITION: Pending
SUMMARY:

Relates to existing Law which provides that injury includes post-traumatic stress that develops during a period in which the injured person is in the service of the department or unit. Makes that provision applicable to active firefighting members of the State Department of State Hospitals, the State Department of Developmental Services, and the Military Department, and the Department of Veterans Affairs, including security officers of the Department of Justice when performing assigned duties.

STATUS:

08/30/2021 In ASSEMBLY. Read second time and amended. To second reading.
08/30/2021 In ASSEMBLY. To Inactive File.

CA SB 335

AUTHOR: Cortese [D]
TITLE: Workers' Compensation: Liability
INTRODUCED: 02/08/2021
LAST AMEND: 03/10/2021
DISPOSITION: Pending
SUMMARY:

Reduces the time periods after the date the claim form is filed with an employer in which the injury is presumed compensable and the presumption is rebuttable only by evidence discovered subsequent to the time period for certain injuries or illnesses, including hernia, heart trouble, pneumonia, or tuberculosis, among others, sustained in the course of employment of a specified member of law enforcement or a specified first responder.

STATUS:

07/13/2021 In ASSEMBLY Committee on INSURANCE: Failed passage.

BROWN ACT

CA AB 1944

AUTHOR: Lee [D]
TITLE: Local Government: Open and Public Meetings
INTRODUCED: 02/10/2022
LAST AMEND: 05/25/2022
DISPOSITION: Pending
SUMMARY:

Requires the agenda to identify any member of the legislative body that will participate in the meeting remotely. Requires an updated agenda reflecting all of the members participating in the meeting remotely to be posted, if a member of the legislative body elects to participate in the meeting remotely after the agenda is posted.

STATUS:

06/22/2022 In SENATE Committee on GOVERNANCE AND FINANCE: Not heard.
BOR_Position: Support *05/05/2022*
IBLC_Recommendation: Support *04/06/2022*

Staff_Recommendation: Support

CA AB 2449

AUTHOR: Rubio [D]
TITLE: Open Meetings: Local Agencies: Teleconferences
INTRODUCED: 02/17/2022
LAST AMEND: 06/23/2022
DISPOSITION: Pending
SUMMARY:

Authorizes a member to participate remotely under specified circumstances, including participating remotely for just cause or due to emergency circumstances. Relates to the emergency circumstances basis for remote participation would be contingent on a request to, and action by, the legislative body. Defines terms for purposes of these teleconferencing provisions.

STATUS:

06/23/2022 From SENATE Committee on JUDICIARY with author's amendments.
06/23/2022 In SENATE. Read second time and amended. Re-referred to Committee on JUDICIARY.

CA AB 2647

AUTHOR: Levine [D]
TITLE: Local Government: Open Meetings
INTRODUCED: 02/18/2022
LAST AMEND: 04/19/2022
DISPOSITION: Pending
SUMMARY:

Requires a local agency to make those writings distributed to the members of the governing board available for public inspection at a public office or location that the agency designates and list the address of the office or location on the agenda for all meetings of the legislative body of the agency unless the local agency meets certain requirements, including the local agency immediately posts the writings on the local agency's internet website in a position and manner that makes it clear.

STATUS:

06/22/2022 In SENATE Committee on GOVERNANCE AND FINANCE: Not heard.

CA SB 1100

AUTHOR: Cortese [D]
TITLE: Open Meetings: Orderly Conduct
INTRODUCED: 02/16/2022
LAST AMEND: 06/06/2022
DISPOSITION: Pending
SUMMARY:

Authorizes the presiding member of the legislative body conducting a meeting to remove an individual for disrupting the meeting. Requires removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal.

STATUS:

06/22/2022 In ASSEMBLY. Read second time. To third reading.

PUBLIC RECORDS ACT

CA AB 343

AUTHOR: Fong [R]

TITLE: California Public Records Act Ombudsperson
INTRODUCED: 01/28/2021
LAST AMEND: 06/15/2022
DISPOSITION: Pending
SUMMARY:

Requires the California Public Records Act Ombudsperson to create a process through which a person whose information is contained in a record being reviewed may intervene to assert their privacy and confidentiality rights, and would otherwise require the ombudsperson to maintain the privacy and confidentiality of records, as provided.

STATUS:

06/21/2022 From SENATE Committee on JUDICIARY: Do pass to Committee on GOVERNMENTAL ORGANIZATION. (11-0)

CA AB 386

AUTHOR: Cooper [D]
TITLE: Public Employees Retirement: Investments: Confidential
INTRODUCED: 02/02/2021
LAST AMEND: 06/29/2021
DISPOSITION: Pending
SUMMARY:

Exempts from disclosure under the California Public Records Act specified records regarding an internally managed private loan made directly by the Public Employees' Retirement Fund. Provides that these records would include quarterly and annual financial statements of the borrower or its constituent owners, unless the information has already been publicly released by the keeper of the information. Prescribes specified exceptions to this exemption from disclosure.

STATUS:

07/13/2021 In SENATE Committee on JUDICIARY: Failed passage.
07/13/2021 In SENATE Committee on JUDICIARY: Reconsideration granted.

SOCIAL SECURITY

US HR 82

SPONSOR: Davis R [R]
TITLE: Government Pension Offset Repeal
INTRODUCED: 01/04/2021
DISPOSITION: Pending
SUMMARY:

Amends the Social Security Act; repeals the Government pension offset and windfall elimination provisions.

STATUS:

01/04/2021 INTRODUCED.
01/04/2021 To HOUSE Committee on WAYS AND MEANS.
BOR_Position: Support *05/05/2021*
IBLC_Recommendation: Support *04/15/2021*
Staff_Recommendation: Support

US HR 2337

SPONSOR: Neal [D]
TITLE: Noncovered Employment
INTRODUCED: 04/01/2021
DISPOSITION: Pending
SUMMARY:

Amends Title II of the Social Security Act to provide an equitable Social Security

formula for individuals with noncovered employment and to provide relief for individuals currently affected by the Windfall Elimination Provision.

STATUS:

04/01/2021	INTRODUCED.
04/01/2021	To HOUSE Committee on WAYS AND MEANS.
BOR_Position:	Support *09/01/2021*
IBLC_Recommendation:	Support *08/12/2021*
Staff_Recommendation:	Support

US HR 5723

SPONSOR:	Larson [D]
TITLE:	Social Security System Benefits
INTRODUCED:	10/26/2021
DISPOSITION:	Pending

SUMMARY:

Protects our Social Security system and improve benefits for current and future generations.

STATUS:

10/26/2021	In HOUSE Committee on WAYS AND MEANS: Referred to Subcommittee on SOCIAL SECURITY.

US S 1302

SPONSOR:	Brown S [D]
TITLE:	Pension Offset
INTRODUCED:	04/22/2021
DISPOSITION:	Pending

SUMMARY:

Amends Title II of the Social Security Act to repeal the government pension offset and windfall elimination provisions.

STATUS:

04/22/2021	INTRODUCED.
04/22/2021	In SENATE. Read second time.
04/22/2021	To SENATE Committee on FINANCE.
BOR_Position:	Support *09/01/2021*
IBLC_Recommendation:	Support *08/12/2021*
Staff_Recommendation:	Support

HEALTHCARE

US HR 4148

SPONSOR:	Malinowski [D]
TITLE:	First Responders Medicare Option
INTRODUCED:	06/24/2021
DISPOSITION:	Pending

SUMMARY:

Amends Title XVIII of the Social Security Act to provide an option for first responders age 50 to 64 who are separated from service due to retirement or disability to buy into Medicare.

STATUS:

06/24/2021	INTRODUCED.
06/24/2021	To HOUSE Committee on WAYS AND MEANS.
06/24/2021	To HOUSE Committee on ENERGY AND COMMERCE.
06/25/2021	In HOUSE Committee on ENERGY AND COMMERCE: Referred to Subcommittee on HEALTH.

US S 2236

SPONSOR:	Brown S [D]
TITLE:	Medicare Buy In Option for First Responders

INTRODUCED: 06/24/2021
DISPOSITION: Pending
SUMMARY:

Amends Title XVIII of the Social Security Act to provide an option for first responders age 50 to 64 who are separated from service due to retirement or disability to buy into Medicare.

STATUS:

06/24/2021	INTRODUCED.
06/24/2021	In SENATE. Read second time.
06/24/2021	To SENATE Committee on FINANCE.

US S 4312

SPONSOR: Brown S [D]
TITLE: Health and Long Term Care Insurance Distributions
INTRODUCED: 05/25/2022
DISPOSITION: Pending
SUMMARY:

Amends the Internal Revenue Code of 1986 to repeal the direct payment requirement on the exclusion from gross income of distributions from governmental plans for health and long term care insurance.

STATUS:

05/25/2022	INTRODUCED.
05/25/2022	In SENATE. Read second time.
05/25/2022	To SENATE Committee on FINANCE.

LACERA Los Angeles County Employees Retirement Association
300 N. Lake Ave., Pasadena, CA 91101 / PO Box 7060, Pasadena, CA 91109-7060 / www.lacera.com / 626/564-6132 • 800/786-6464

June 21, 2022

The Honorable Dave Cortese, Chair
Senate Committee on Labor, Public Employment
And Retirement
1021 O Street, Room 6740
Sacramento, CA 95814

RE: Support AB 1971 (Cooper)

Dear Chair Cortese:

The Los Angeles County Employees Retirement Association (LACERA) respectfully requests your Committee's support of Assembly Bill 1971, which is sponsored by the State Association of County Retirement Systems (SACRS).

SACRS represents 20 independent county retirement systems, including LACERA, which operate under the County Employees Retirement Law of 1937 (CERL). The bill makes important amendments to CERL related to absences and furloughs of employees as well as a clarification for retired persons of county retirement systems who serve on that county's boards or commissions.

The bill also contains an important provision proposed by LACERA to SACRS that would equalize the treatment of members who apply for disability retirement after retiring for service with regard to changing their optional allowances. These amendments ensure efficient and effective administration of plan benefits for our members.

The Board of Retirement of LACERA respectfully requests your Committee's support and an "aye" vote for AB 1971.

Respectfully submitted,

Santos H. Kreimann
Chief Executive Officer

SHK:bwl

cc: Members of the Senate LPE&R Committee
Shari McHugh, McHugh Koepke & Associates
Naomi Padron, McHugh Koepke & Associates

LACERA

June 24, 2022

TO: Each Trustee
Board of Retirement

FROM: Francis J. Boyd FB
Sr. Staff Counsel

FOR: **July 6, 2022, Board of Retirement Meeting**

SUBJECT: **LACERA'S PROCEDURES FOR DISABILITY RETIREMENT HEARINGS UPDATE PRESENTATION FOR REFEREES, APPLICANT ATTORNEYS, AND STAFF**

FOR INFORMATION ONLY

On December 1, 2021, the Board of Retirement approved staff's recommendation to update LACERA's Procedures for Disability Retirement Hearings. The updates were necessary to comport with the practices followed during the appeal process, clarify some timing inconsistencies, and facilitate the electronic service of records.

To ensure transparency of LACERA's appeal process, the Legal Office worked with the Disability Litigation Office and invited our referees, applicant attorneys, and staff involved in the appeal process to attend a virtual presentation reviewing the updates. The presentation also reviewed LACERA's appeal procedures for pro per applicants with psychiatric claims, procedures for felony-forfeiture appeals, and the use of the first-floor training room for hearings in response to the COVID-19 social distance restrictions.

The same presentation was held on two separate dates, June 17, 2022, and June 24, 2022, to provide ample opportunity for invitees to attend. Approximately 34 people attended the meetings which were well received.

In response to social-distancing requirements related to COVID-19, disability-retirement hearings have been held in LACERA's first-floor training room which is much larger than the hearing room located on the sixth floor of the building. At both meetings, referees and applicant attorneys stated that they preferred the first-floor training room for the hearings and hoped that LACERA would continue to utilize this room or a room of similar size after it is no longer necessary to social-distance because of COVID-19. I responded that I would raise this issue with Administrative Services and the Executive Office.

LACERA

FOR INFORMATION ONLY

June 22, 2022

TO: Each Trustee
Board of Retirement

FROM: Ricki Contreras, Manager
Disability Retirement Services

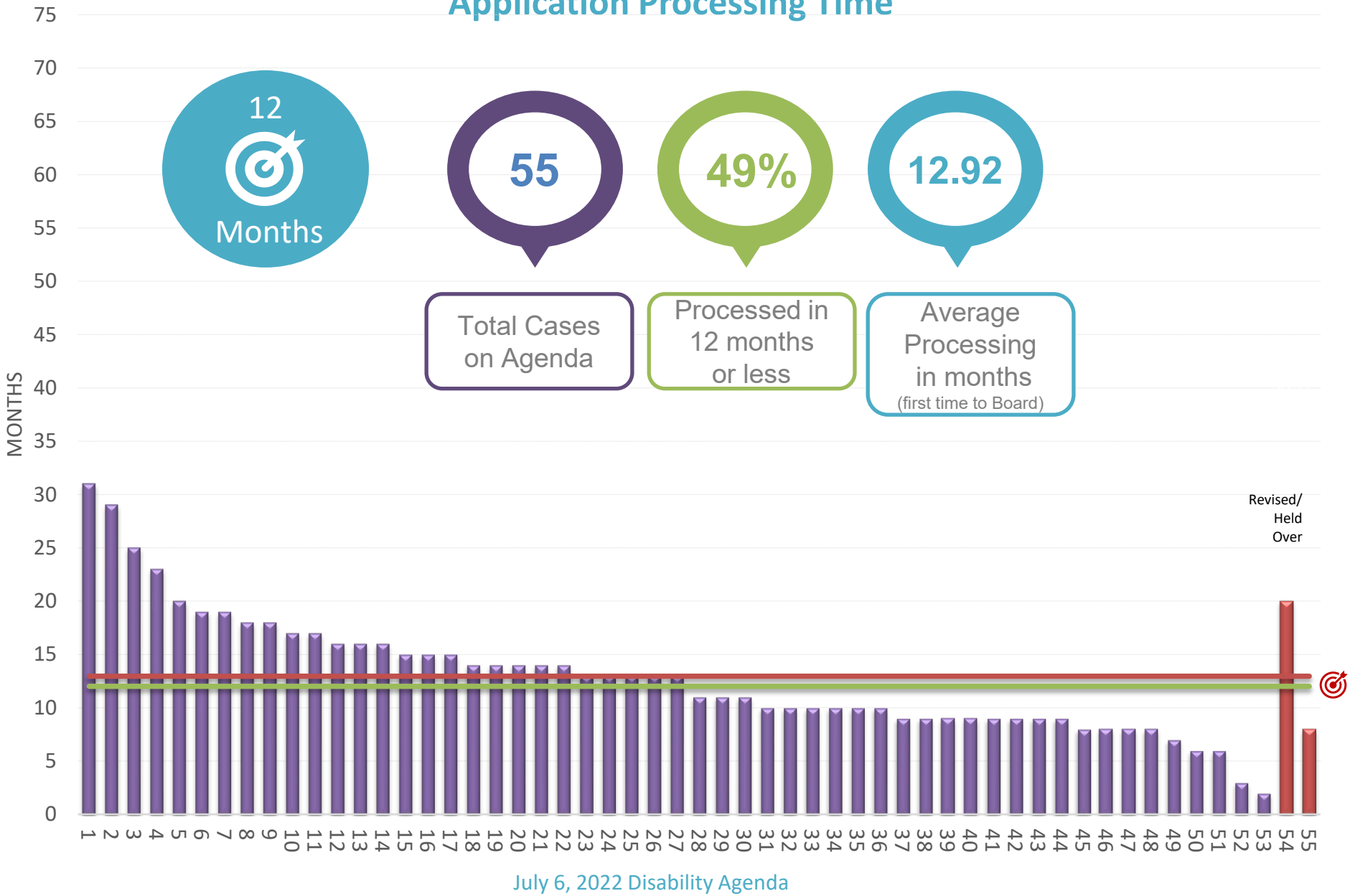
FOR: July 6, 2022, Board of Retirement Meeting

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 July 6, 2022, Disability Retirement Applications Agenda.

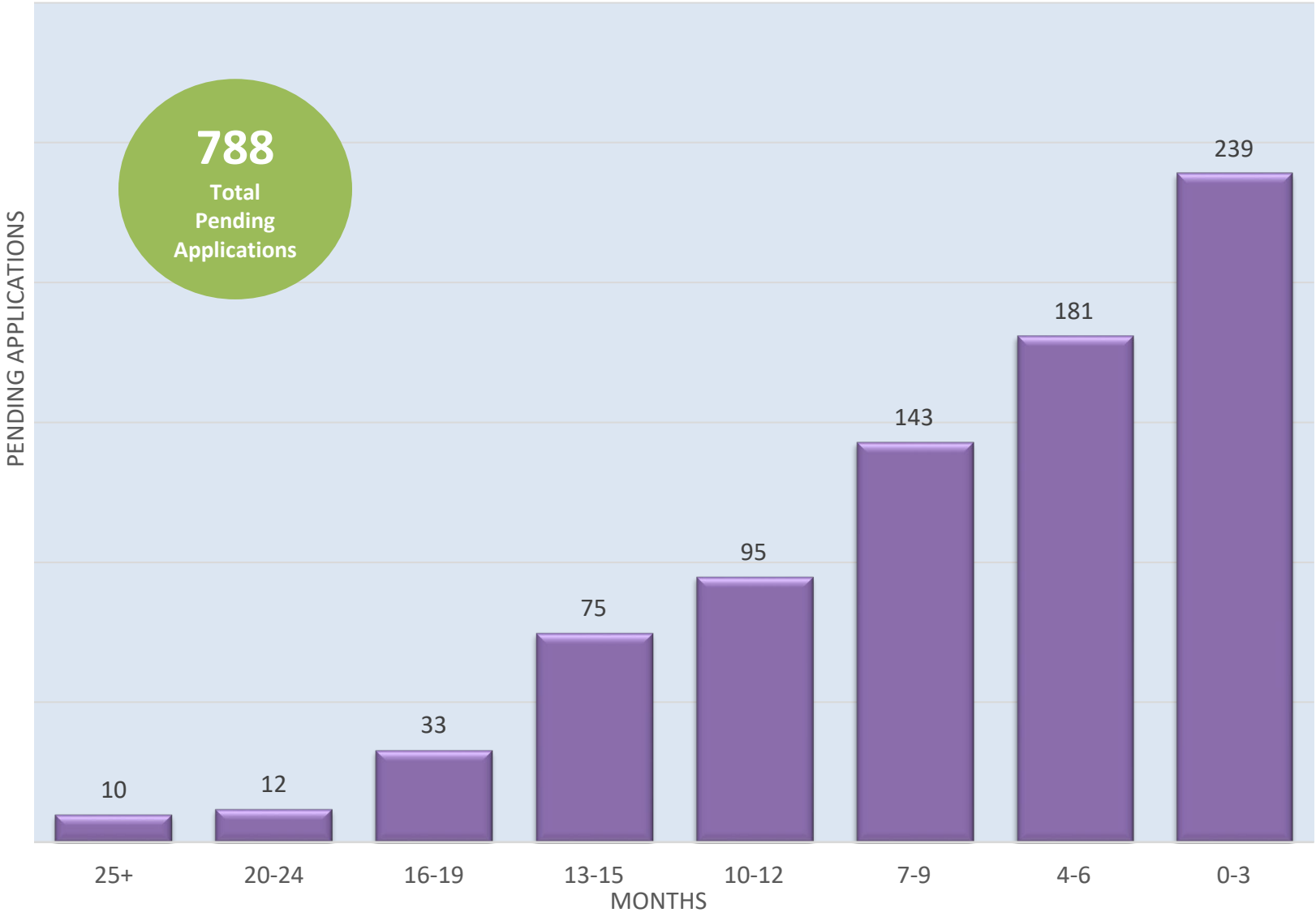
Consent & Non-Consent Calendar		
Number of Applications	55	
Average Processing Time (in Months)	12.92	
Revised/Held Over Calendar		
Number of Applications	2	
Processing Time Per Case (in Months)	Case 1 20	Case 2 2-Year Review 8
Total Average Processing Time All **55** Cases on Agenda	12.96	

DISABILITY RETIREMENT SERVICES
Application Processing Time



July 6, 2022 Disability Agenda

DISABILITY RETIREMENT SERVICES
Pending Applications/Months



As of June 22, 2022

LACERA

FOR INFORMATION ONLY

June 22, 2022

TO: Each Trustee
Board of Retirement
Board of Investments

FROM: Ted Granger TG
Interim Chief Financial Officer

FOR: July 6, 2022 Board of Retirement Meeting
July 13, 2022 Board of Investments Meeting

SUBJECT: **MONTHLY TRAVEL & EDUCATION REPORT – MAY 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 May 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/gj

Attachments

c: L. Lugo
J. Popowich
L. Guglielmo
J. Grabel
S. Rice
R. Van Nortrick

LACERA

TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2021 - 2022

MAY 2022

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Alan Bernstein				
A	1	Edu - NCPERS 2021 Public Pension Funding Forum - New York NY	08/22/2021 - 08/24/2021	Attended
	2	Edu - 2021 SuperReturn North America - Boston MA	10/04/2021 - 10/05/2021	Attended
	3	Edu - Latin America US Real Estate Meeting - South Beach FL	11/29/2021 - 11/30/2021	Attended
B	-	Edu - 2021 Milken Institute Global Conference - Los Angeles CA	10/17/2021 - 10/20/2021	Attended
	-	Edu - SACRS Fall Conference - Los Angeles CA	11/09/2021 - 11/12/2021	Attended
	-	Edu - 2022 SACRS Spring Conference - Rancho Mirage CA	05/10/2022 - 05/13/2022	Attended
V	-	Edu - NACD Women in the Workforce: Beyond Diversity, Equity, and Inclusion - VIRTUAL	04/20/2022 - 04/20/2022	Attended
X	-	Edu - SuperReturn International Berlin - Berlin, Germany	11/09/2021 - 11/12/2021	Canceled
Vivian Gray				
A	1	Edu - NCPERS 2021 Public Pension Funding Forum - New York NY	08/22/2021 - 08/24/2021	Attended
	2	Edu - The Women's Alliance of Saxena White ~ First Annual Diversity Investing Symposium - Delray Beach FL	05/05/2022 - 05/05/2022	Attended
	3	Edu - NCPERS Annual Conference & Exhibition - Washington, DC MD	05/21/2022 - 05/25/2022	Attended
B	-	Edu - SACRS Fall Conference - Los Angeles CA	11/09/2021 - 11/12/2021	Attended
	-	Admin - SACRS Board of Directors Meeting - Rancho Mirage CA	12/14/2021 - 12/14/2021	Attended
	-	Admin - SACRS Board of Directors and Program Committee Meeting - Berkeley CA	01/24/2022 - 01/25/2022	Attended
	-	Edu - 2022 CALAPRS - General Assembly - San Diego CA	03/05/2022 - 03/08/2022	Attended
	-	Admin - SACRS Program Committee Meeting - Long Beach CA	03/22/2022 - 03/23/2022	Attended
	-	Edu - NASP Southern California "Day of Education in Private Equity Conference" - Los Angeles CA	03/23/2022 - 03/24/2022	Attended
	-	Edu - 2022 SACRS Spring Conference - Rancho Mirage CA	05/10/2022 - 05/13/2022	Attended
V	-	Edu - Congressional Black Caucus Foundation - VIRTUAL	09/12/2021 - 09/17/2021	Attended
	-	Edu - Private Credit Outlook: Key Trends and the Road Ahead - VIRTUAL	09/16/2021 - 09/16/2021	Attended
	-	Edu - NASP 32nd Annual Financial Services Virtual Conference - VIRTUAL	09/22/2021 - 09/24/2021	Attended
	-	Edu - New America Alliance: U.S. Economic Recovery - VIRTUAL	11/10/2021 - 11/10/2021	Attended
	-	Edu - CFA Society of Los Angeles - Diversity, Equity, and Inclusion Virtual Conference - VIRTUAL	02/10/2022 - 02/10/2022	Attended
	-	Edu - NASP Women's Forum - VIRTUAL	03/30/2022 - 03/31/2022	Attended
David Green				
B	-	Edu - SACRS Fall Conference - Los Angeles CA	11/09/2021 - 11/12/2021	Attended
	-	Edu - 2022 PPI Winter Roundtable - Westlake Village CA	02/23/2022 - 02/25/2022	Attended
	-	Edu - 2022 CALAPRS - General Assembly - San Diego CA	03/05/2022 - 03/08/2022	Attended
	-	Edu - 2022 Milken Institute Global Conference - Los Angeles CA	05/01/2022 - 05/04/2022	Attended
X	-	Edu - 2021 CII Fall Conference - Chicago IL	09/22/2021 - 09/24/2021	Host Canceled

LACERA

TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2021 - 2022

MAY 2022

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Elizabeth Greenwood				
B	-	Edu - 2021 Milken Institute Global Conference - Los Angeles CA	10/17/2021 - 10/20/2021	Attended
James Harris				
B	-	Edu - CRCEA 2021 Fall Conference - Long Beach CA	11/07/2021 - 11/10/2021	Attended
Patrick Jones				
B	-	Edu - 2021 Milken Institute Global Conference - Los Angeles CA	10/17/2021 - 10/20/2021	Attended
	-	Edu - 2022 CALAPRS - General Assembly - San Diego CA	03/05/2022 - 03/08/2022	Attended
	-	Edu - NASP Southern California "Day of Education in Private Equity Conference" - Los Angeles CA	03/23/2022 - 03/24/2022	Attended
	-	Edu - 2022 Milken Institute Global Conference - Los Angeles CA	05/01/2022 - 05/04/2022	Attended
V	-	Edu - SACRS Public Pension Investment Management Program - VIRTUAL	07/13/2021 - 07/22/2021	Attended
	-	Edu - Harvard Kennedy School Executive Education: Leading Smart Policy Design: A Multisectoral Approach to Economic Decisions - VIRTUAL	09/21/2021 - 10/12/2021	Attended
	-	Edu - Duke University Executive Education Program - Corporate Social Responsibility - VIRTUAL	12/06/2021 - 12/14/2021	Attended
	-	Edu - Harvard Kennedy School Executive Education: Behavioral Insights and Public Policy Program - VIRTUAL	01/31/2022 - 02/16/2022	Attended
	-	Edu - CFA Society of Los Angeles - Diversity, Equity, and Inclusion Virtual Conference - VIRTUAL	02/10/2022 - 02/10/2022	Attended
Shawn Kehoe				
V	-	Edu - Morgan Stanley Virtual Global Insights Day - VIRTUAL	02/09/2022 - 02/09/2022	Attended
X	-	Edu - 2021 Milken Institute Global Conference - Los Angeles CA	10/17/2021 - 10/20/2021	Canceled
	-	Edu - SACRS Fall Conference - Los Angeles CA	11/09/2021 - 11/12/2021	Canceled
Joseph Kelly				
B	-	Edu - 2021 Milken Institute Global Conference - Los Angeles CA	10/17/2021 - 10/20/2021	Attended
V	-	Edu - SACRS Public Pension Investment Management Program - VIRTUAL	07/13/2021 - 07/22/2021	Attended
	-	Edu - Private Credit Outlook: Key Trends and the Road Ahead - VIRTUAL	09/16/2021 - 09/16/2021	Attended
	-	Edu - Pugh Capital 30th Anniversary Virtual Event Series - VIRTUAL	09/22/2021 - 09/22/2021	Attended
	-	Edu - 2021 Institute of Internal Auditors Los Angeles Conference: Governance, Grit and Gravitas - VIRTUAL	10/04/2021 - 10/06/2021	Attended
	-	Edu - NACD Pacific Southwest / USC Marshall Corporate Directors Symposium - November 2021 - VIRTUAL	11/10/2021 - 11/10/2021	Attended
	-	Edu – 2022 CII Spring Conference - VIRTUAL	03/07/2022 - 03/09/2022	Attended
	-	Edu - NACD Pacific Southwest / USC Marshall Corporate Directors - March 2022 - VIRTUAL	03/24/2022 - 03/24/2022	Attended
	-	Edu - ESG - SEC Proposed Rule on Climate Disclosures: Roles for Internal Audit - VIRTUAL	04/06/2022 - 04/06/2022	Attended
	-	Edu - NACD - Future of Water in the Pacific Southwest - VIRTUAL	04/06/2022 - 04/06/2022	Attended
	-	Edu - 2022 Milken Institute Global Conference VIRTUAL - VIRTUAL	05/01/2022 - 05/04/2022	Attended

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TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2021 - 2022

MAY 2022

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Keith Knox				
V	-	Edu - Harvard Business School Audit Committees In A New Era of Governance - VIRTUAL	07/21/2021 - 07/23/2021	Attended
	-	Edu - Pugh Capital 30th Anniversary Virtual Event Series - VIRTUAL	09/22/2021 - 09/22/2021	Attended
	-	Edu - New America Alliance: U.S. Economic Recovery - VIRTUAL	11/10/2021 - 11/10/2021	Attended
	-	Edu - NACD Climate Continuous Learning Cohort Two-Day Program - VIRTUAL	03/31/2022 - 04/01/2022	Attended
X	-	Edu - 2022 Milken Institute Global Conference - Los Angeles CA	05/01/2022 - 05/04/2022	Canceled
Wayne Moore				
B	-	Edu - 2021 Milken Institute Global Conference - Los Angeles CA	10/17/2021 - 10/20/2021	Attended
	-	Edu - NASP Southern California "Day of Education in Private Equity Conference" - Los Angeles CA	03/23/2022 - 03/24/2022	Attended
	-	Edu - 2022 Milken Institute Global Conference - Los Angeles CA	05/01/2022 - 05/04/2022	Attended
William Pryor				
A	1	Edu - IFEBP Healthcare Management and Investments Institute Conference - Phoenix AZ	04/25/2022 - 04/28/2022	Attended
	2	Edu - NCPERS Annual Conference & Exhibition - Washington, DC MD	05/21/2022 - 05/25/2022	Attended
B	-	Edu - SACRS Fall Conference - Los Angeles CA	11/09/2021 - 11/12/2021	Attended
V	-	Edu – 2022 CII Spring Conference - VIRTUAL	03/07/2022 - 03/09/2022	Attended
	-	Edu - CALAPRS Special Virtual Trustee Round Table - VIRTUAL	04/29/2022 - 04/29/2022	Attended
Les Robbins				
B	-	Edu - CRCEA 2021 Fall Conference - Long Beach CA	11/07/2021 - 11/10/2021	Attended
V	-	Edu - CALAPRS Trustees Roundtable - VIRTUAL	10/29/2021 - 10/29/2021	Attended

TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2021 - 2022

MAY 2022

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Gina Sanchez				
A	1	Edu - 2022 CII Spring Conference - Washington, DC MD	03/07/2022 - 03/09/2022	Attended
	2	Edu - The Women's Alliance of Saxena White ~ First Annual Diversity Investing Symposium - Delray Beach FL	05/05/2022 - 05/05/2022	Attended
	3	Edu - NCPERS Annual Conference & Exhibition - Washington, DC MD	05/21/2022 - 05/25/2022	Attended
B	-	Edu - 2021 Milken Institute Global Conference - Los Angeles CA	10/17/2021 - 10/20/2021	Attended
	-	Edu - SACRS Fall Conference - Los Angeles CA	11/09/2021 - 11/12/2021	Attended
	-	Edu - 2022 PPI Winter Roundtable - Westlake Village CA	02/23/2022 - 02/25/2022	Attended
	-	Edu - NASP Southern California "Day of Education in Private Equity Conference" - Los Angeles CA	03/23/2022 - 03/24/2022	Attended
	-	Edu - 2022 Annual Pension Bridge - San Francisco CA	04/18/2022 - 04/20/2022	Attended
	-	Edu - 2022 Milken Institute Global Conference - Los Angeles CA	05/01/2022 - 05/04/2022	Attended
	-	Edu - 2022 SACRS Spring Conference - Rancho Mirage CA	05/10/2022 - 05/13/2022	Attended
V	-	Edu - 2021 CII Fall Conference - VIRTUAL	09/22/2021 - 09/24/2021	Attended
	-	Edu - 2021 Virtual NACD Summit - VIRTUAL	10/04/2021 - 10/08/2021	Attended
	-	Edu - PRI Roundtable: The Road to Net-Zero with Ophir Bruck - VIRTUAL	10/12/2021 - 10/12/2021	Attended
	-	Edu - PRI Roundtable: Equity, Diversity & Inclusion with Ophir Bruck - VIRTUAL	10/14/2021 - 10/14/2021	Attended
	-	Edu - CALAPRS Trustees Roundtable - VIRTUAL	10/29/2021 - 10/29/2021	Attended
	-	Edu - Institutional ESG Investing Conference North America - VIRTUAL	04/10/2022 - 04/10/2022	Attended
X	-	Edu - 2021 CII Fall Conference - Chicago IL	09/22/2021 - 09/24/2021	Host Canceled
Herman Santos				
A	1	Edu - NCPERS 2021 Public Pension Funding Forum - New York NY	08/22/2021 - 08/24/2021	Attended
	2	Edu - 2022 CII Spring Conference - Washington, DC MD	03/07/2022 - 03/09/2022	Attended
	3	Edu - Congress of Private Capital and Entrepreneurial Capital of the Pacific Alliance - Bogota, Colombia	04/26/2022 - 04/27/2022	Attended
	4	Edu - The Women's Alliance of Saxena White ~ First Annual Diversity Investing Symposium - Delray Beach FL	05/05/2022 - 05/05/2022	Attended
B	-	Edu - 2021 Milken Institute Global Conference - Los Angeles CA	10/17/2021 - 10/20/2021	Attended
	-	Edu - PPI Asia Pacific Roundtable - Pasadena CA	10/27/2021 - 10/29/2021	Attended
	-	Edu - SACRS Fall Conference - Los Angeles CA	11/09/2021 - 11/12/2021	Attended
	-	Admin - SACRS Board of Directors Meeting - Rancho Mirage CA	12/14/2021 - 12/14/2021	Attended
	-	Edu - 2022 PPI Winter Roundtable - Westlake Village CA	02/23/2022 - 02/25/2022	Attended
V	-	Edu - PPI Roundtable - July 2021 - VIRTUAL	07/13/2021 - 07/15/2021	Attended
	-	Edu - Private Credit Outlook: Key Trends and the Road Ahead - VIRTUAL	09/16/2021 - 09/16/2021	Attended
X	-	Edu - Global Investors Annual Meeting - New York NY	12/13/2021 - 12/14/2021	Canceled
	-	Edu - NASP Southern California "Day of Education in Private Equity Conference" - Los Angeles CA	03/23/2022 - 03/24/2022	Canceled

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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Documents not attached are exempt from disclosure under the California Public Records Act and other legal authority.

For further information, contact:
LACERA
Attention: Public Records Act Requests
300 N. Lake Ave., Suite 620
Pasadena, CA 91101

LACERA

May 31, 2021

TO: Trustees,
Board of Investments

FROM: Christine Roseland CR
Senior Staff Counsel

FOR: June 8, 2022 Board of Investments Meeting

SUBJECT: **Legal Transactions Year End Report**

Please find attached a brief report summarizing the legal work that the Transactions Section of the Legal Division accomplished in calendar year 2021. It includes a breakdown of work done by asset class and LACERA divisions both in terms of number of assignments or transactions and the dollar amount that those assignments or transactions represent. It also provides some insight into LACERA operations, workflow trends and staff productivity.

Attachment

c: Santos H. Kreimann
Luis Lugo
Laura Guglielmo
Jonathan Grabel
JJ Popowich
Vache Mahseredjian
Christopher Wagner
Esmerelda Del Bosque
Jim Rice
Jude Perez
Steven Rice
John Harrington
Earl Buehner
Board of Retirement

LACERA
Los Angeles County Employees
Retirement Association

Legal Transactions Year End Report

2021

THE REPORT

This report provides a summary of the legal work that the Transactions Section of the Legal Division accomplished in calendar year 2021 in terms of number of tasks and the dollar amount that those tasks represent (such as the value of an investment commitment or commercial contracts). The report also includes charts that provide a visual representation of this work and provide a comparison to prior years. As shown below, the group handled 753 projects during 2021, representing $8,756,982,907 in contract value.

By way of background, the Transactions Section generally consists of three attorneys, two paralegals, and two management secretaries.[1] Those seven individuals are responsible for handling all investment-related and commercial transactional matters, including drafting, negotiating, and reviewing investment management agreements, limited partnership agreements and side letters, managing title holding companies, acquisitions, dispositions, and financings as well as drafting and reviewing commercial contracts, and responding to Public Records Act requests. In performing their work, the team collaborates closely with their clients in the Investment Division and in other LACERA divisions to accomplish their business objectives and manage organizational risk. The team's objective is not merely to consummate deals and transactions but to protect the pension fund from liability and excessive risk, mitigate losses, minimize fees, assist stakeholders in making informed decisions, provide advice, present alternatives and solutions and collaborate on organizational initiatives such as T.I.D.E., business continuity and disaster recovery planning. In addition, outside counsel may be engaged to assist with certain matters while overseen by in-house counsel and those matters are included in the figures presented in this report

[1]Currently, the team is composed of two attorneys and two paralegals and is in the process of recruiting for the existing vacant positions.

CALENDAR YEAR END LEGAL TRANSACTIONS AS OF 12-31-21

INVESTMENT PROJECT	TRANSACTION TOTAL	TRANSACTION AMOUNT
Private Equity	253	$2,324,785,121
Public Markets (Equity/Fixed Income)	23	$0
Hedge Funds	38	$3,020,000,000
Real Assets	37	$1,785,279,852
Portfolio Analytics	27	$1,274,340
Real Estate	104	$1,500,040,796
Investment Prospects[2]	29	$115,009,964
TOTAL INVESTMENTS	**511**	**$8,746,390,073**
Non-Investment Vendor Agreements	151	$10,592,834
TOTAL (Investments and Vendor Transactions)	**662**	**$8,756,982,907**

[2]This category represents matters and transactions that are submitted for legal review and at some point during that review, the owner of the project abandons or terminates it for various reasons. For example, staff may be considering a co-investment that they submit for legal review given the tight closing deadlines but then decide not to proceed with it either for business or legal reasons. If the Legal team started working on such a matter, it is reflected in this chart as work or a prospect not having been completed.

CALENDAR YEAR END PUBLIC RECORDS ACT RESPONSES AS OF 12-31-21

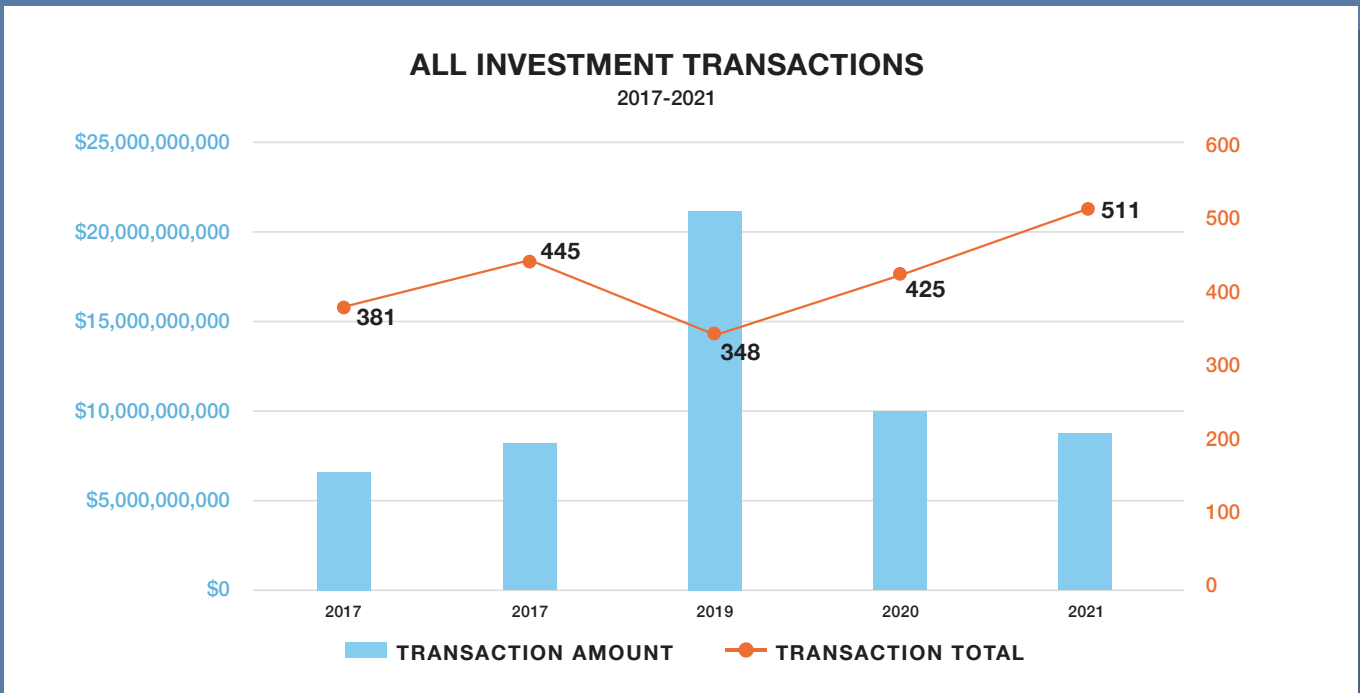
TYPE OF ACTIVITY	TRANSACTION TOTAL	TRANSACTION AMOUNT
Public Records Act Responses	91	$0.00

CONTRACT VALUE

The following graphs represent the legal work performed as a function of the aggregate amount of the contract, commitment or value associated with the underlying documents as well as a function of the number of transactions completed or projects performed. As an example of contract value, if the Board of Investments (BOI) approved a $300 million commitment to a hedge fund manager, it is recorded as a project valued at $300 million for purposes of this report and is then compared to prior years. As an example of the number of projects, if the BOI approved a commitment to a hedge fund manager for $300 million, it is counted as one project. Similarly, if staff works on a consent or amendment that a manager provides for review and approval, it is counted as one. Therefore, some projects or transactions may take several weeks or months, while others may take an hour.

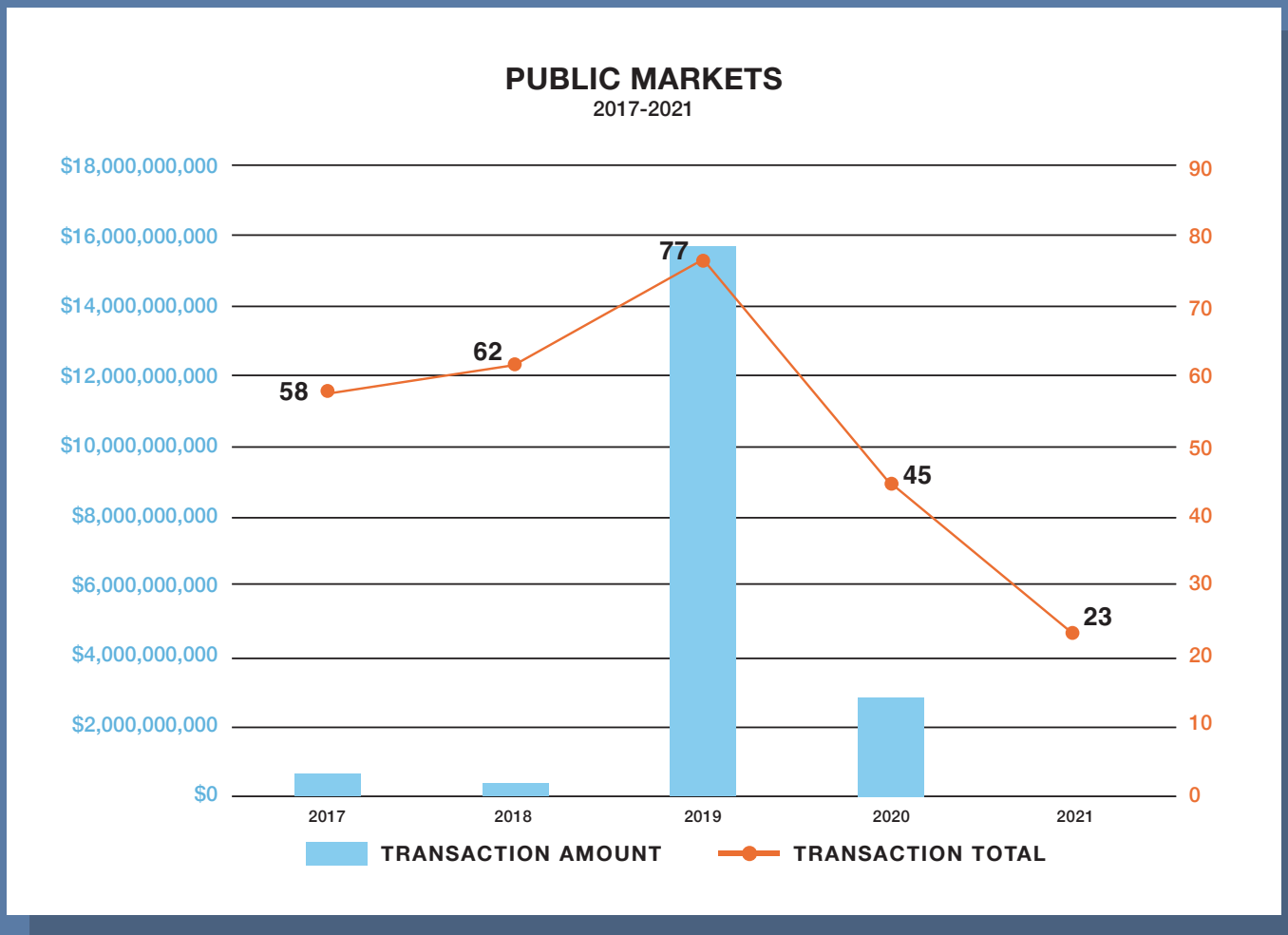
ALL INVESTMENT TRANSACTIONS
YEARLY COMPARISON 2017 – 2021

ALL INVESTMENT TRANSACTIONS 2017-2021		
YEAR	TRANSACTION TOTAL	TRANSACTION AMOUNT
2017	381	$6,497,218,140
2018	445	$8,160,258,686
2019	348	$21,297,627,581
2020	425	$10,006,466,834
2021	511	$8,746,390,073



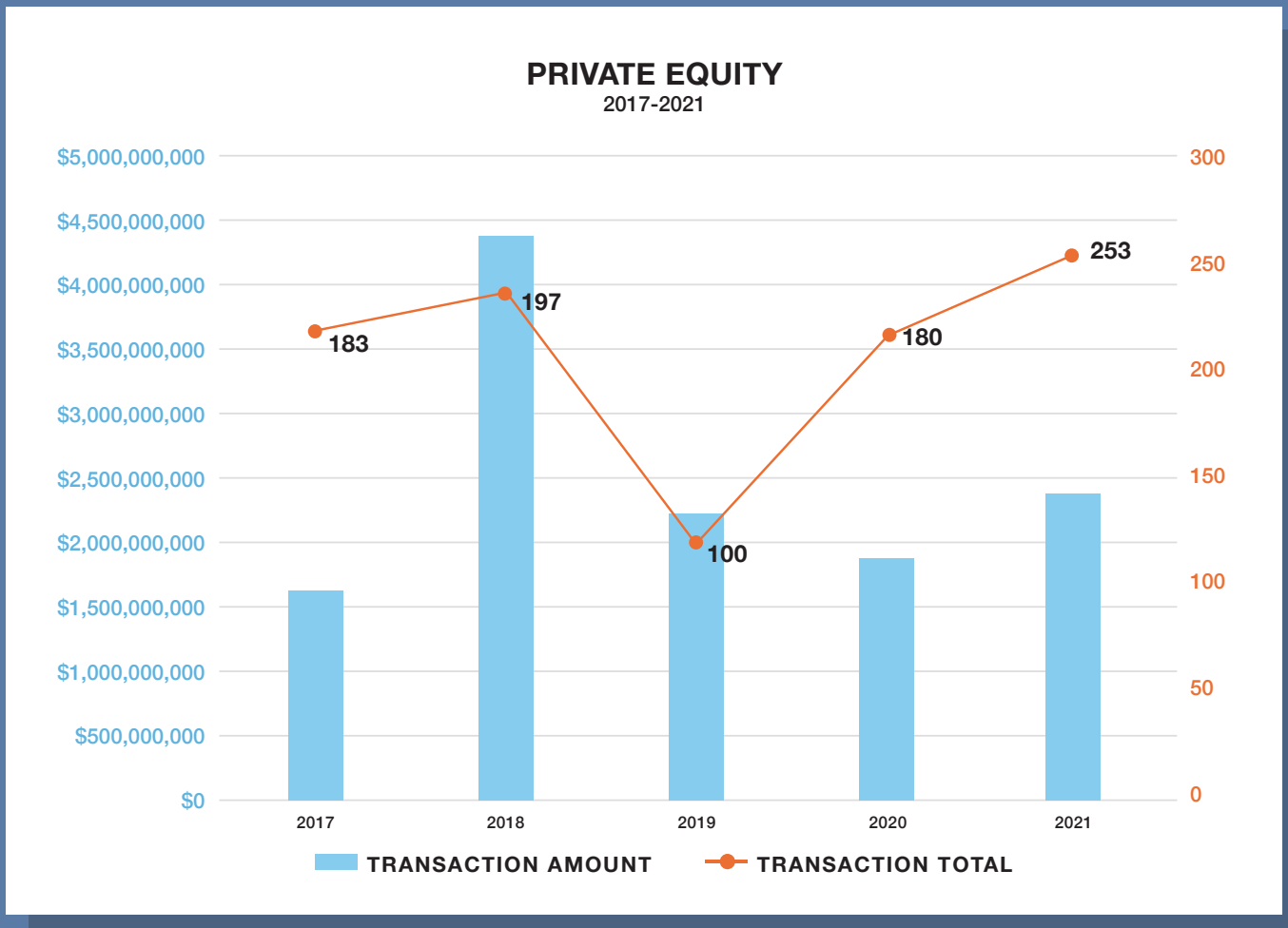
PUBLIC MARKETS (EQUITY/FIXED INCOME) TRANSACTIONS
YEARLY COMPARISON 2017-2021

PUBLIC MARKETS 2017-2021		
YEAR	TRANSACTION TOTAL	TRANSACTION AMOUNT
2017	58	$677,174,200
2018	62	$345,078,413
2019	77	$15,700,000,000
2020	45	$2,901,447,000
2021	23	$0



PRIVATE EQUITY TRANSACTION AMOUNT[3]
YEARLY COMPARISON 2017-2021

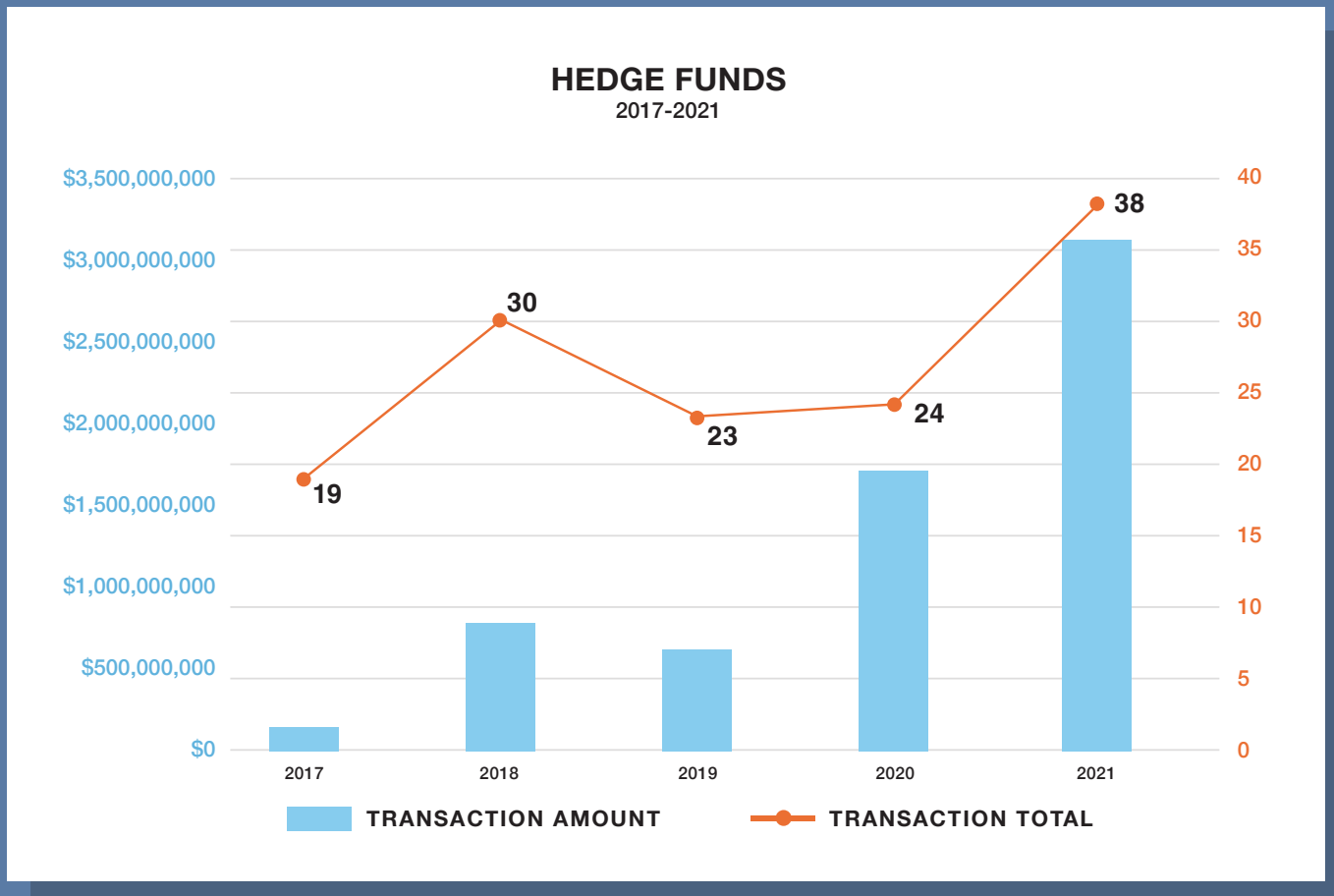
PRIVATE EQUITY 2017-2021		
YEAR	TRANSACTION TOTAL	TRANSACTION AMOUNT
2017	183	$1,653,457,925
2018	197	$4,406,599,162
2019	100	$2,243,415,762
2020	180	$1,885,986,886
2021	253	$2,324,785,121



[3]Methodology on transaction amount: Some matters have no value (for example, terminations, consents, fee amendments etc.) so they are given a value of 0. If an agreement has a five-year term then the entire five-year value of that contract is recorded for that initial year when the contract is entered into. Some contracts are too difficult to value (for example, a Human Resources agreement for temporary staff when the hours and duration of employment for the temp staff is unknown) and in such cases, the contract is given a value of 0 for purposes of this report.

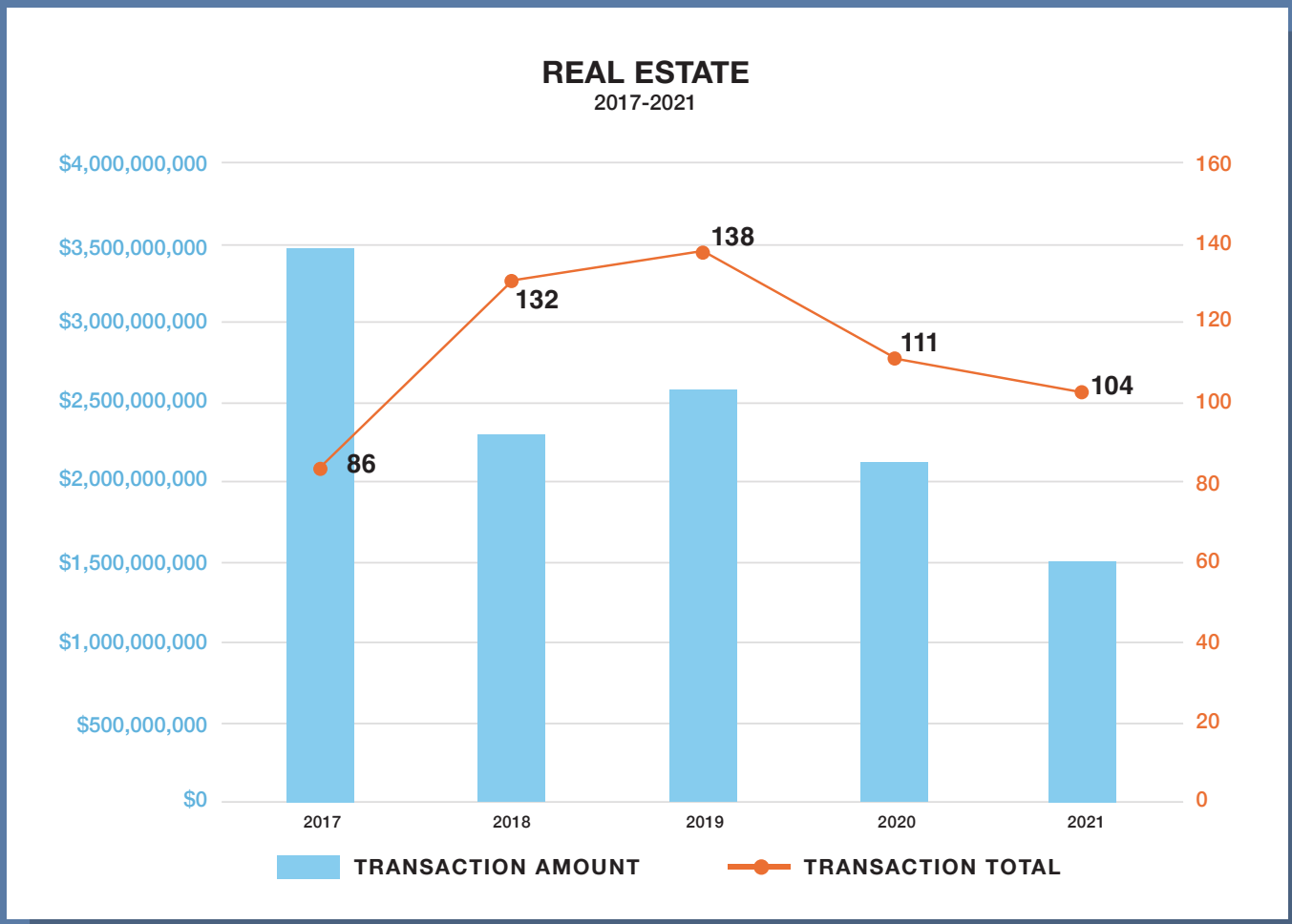
HEDGE FUNDS TRANSACTION AMOUNT
YEARLY COMPARISON 2017-2021

HEDGE FUNDS 2017-2021		
YEAR	TRANSACTION TOTAL	TRANSACTION AMOUNT
2017	19	$153,700,000
2018	30	$882,400,000
2019	23	$625,000,000
2020	24	$1,717,000,000
2021	38	$3,020,000,000



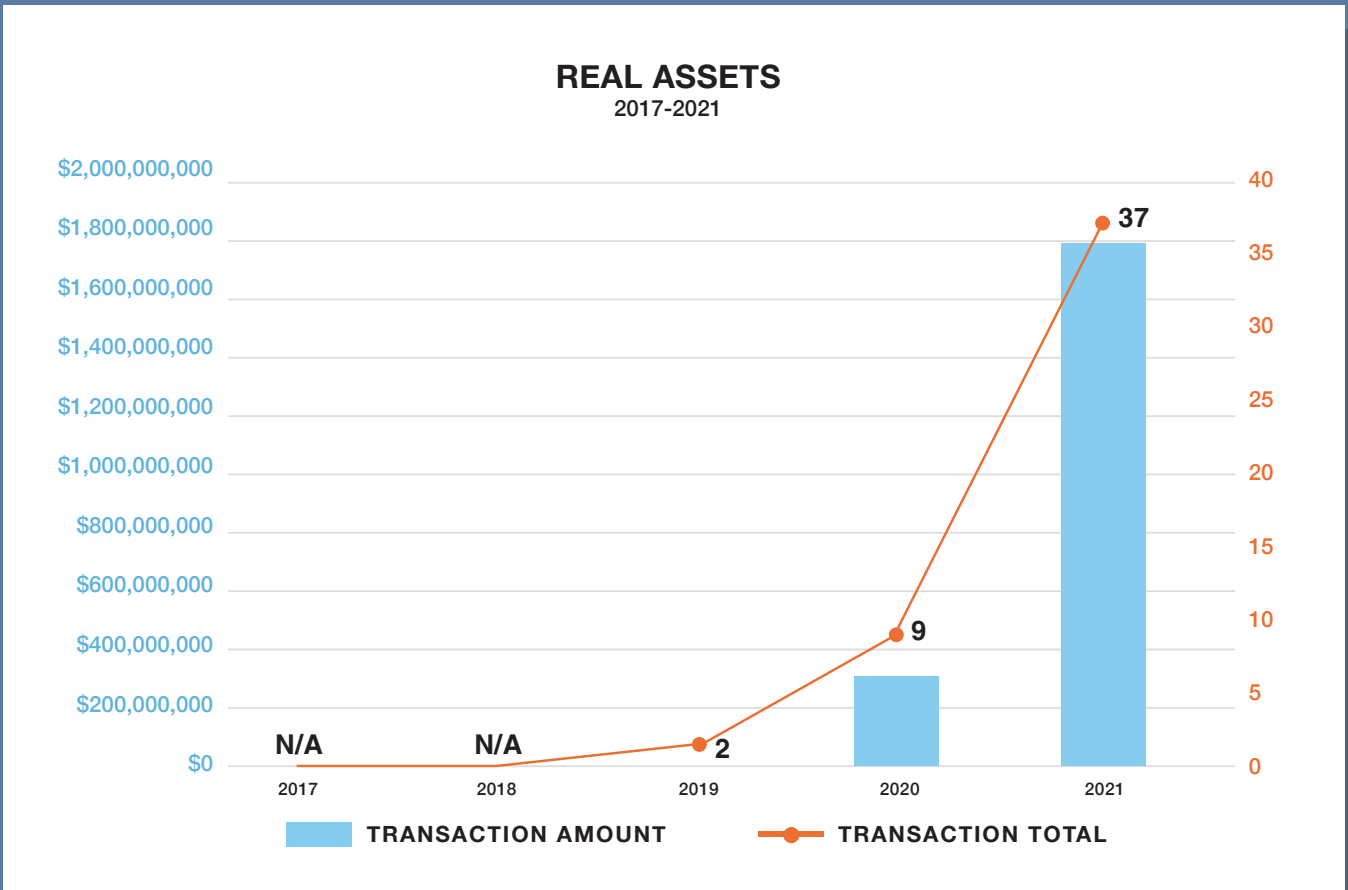
REAL ESTATE TRANSACTION AMOUNT
YEARLY COMPARISON 2017-2021

REAL ESTATE 2017-2021		
YEAR	TRANSACTION TOTAL	TRANSACTION AMOUNT
2017	86	$3,469,239,528
2018	132	$2,301,181,111
2019	138	$2,578,464,619
2020	111	$2,113,222,250
2021	104	$1,500,040,796



REAL ASSETS TRANSACTIONS[4]
YEARLY COMPARISON 2017-2021

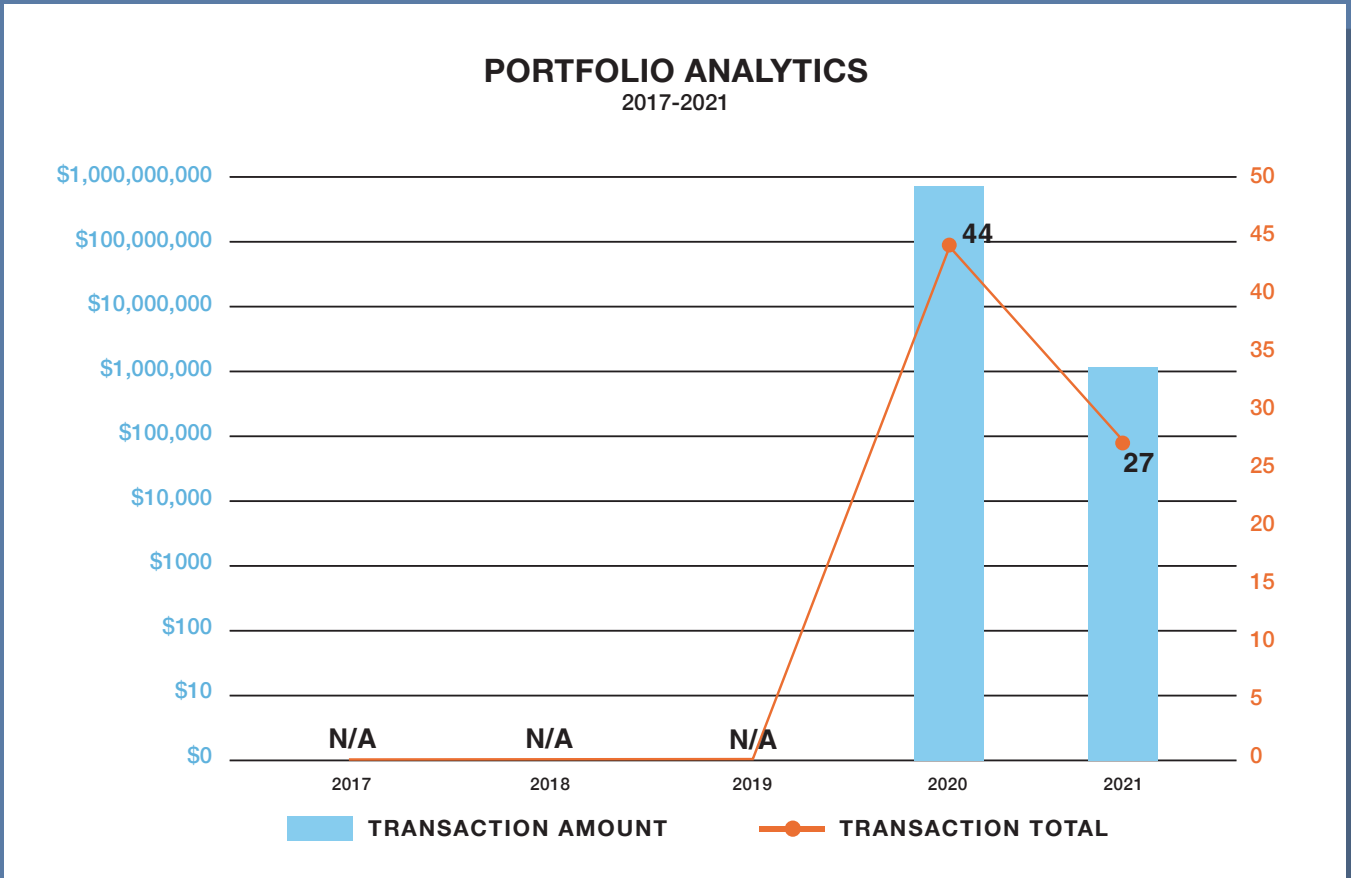
REAL ASSETS 2017-2021		
YEAR	TRANSACTION TOTAL	TRANSACTION AMOUNT
2017	0	$0
2018	0	$0
2019	2	$747,200
2020	9	$320,000,000
2021	37	$1,785,279,852



[4]This asset class has only been tracked since 2019 and therefore, prior years do not exist for comparison.

PORTFOLIO ANALYTICS TRANSACTIONS[5]
YEARLY COMPARISON 2017-2021

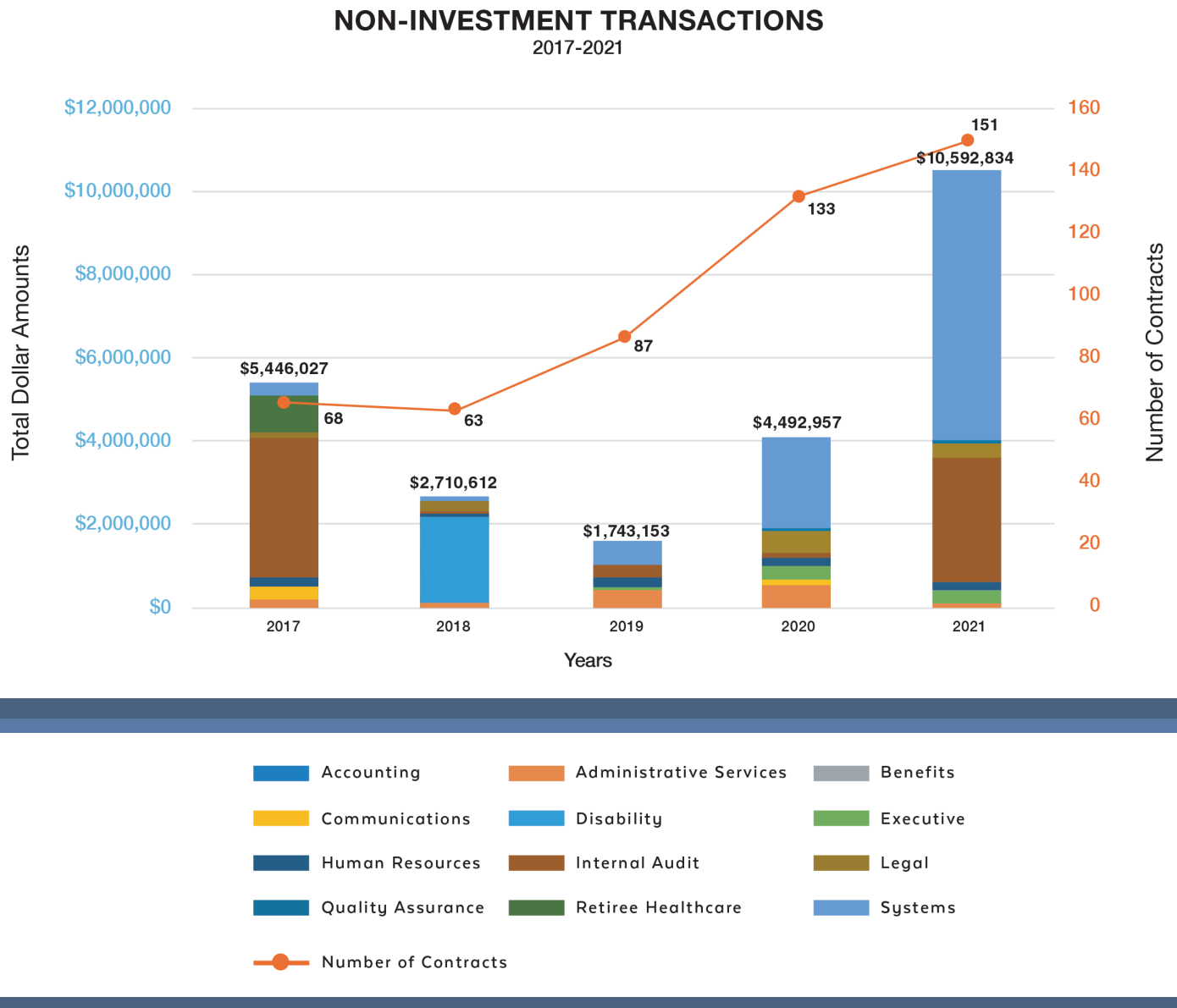
PORTFOLIO ANALYTICS 2017-2021		
YEAR	TRANSACTION TOTAL	TRANSACTION AMOUNT
2017	N/A	N/A
2018	N/A	N/A
2019	N/A	N/A
2020	44	$603,810,698
2021	27	$1,274,340

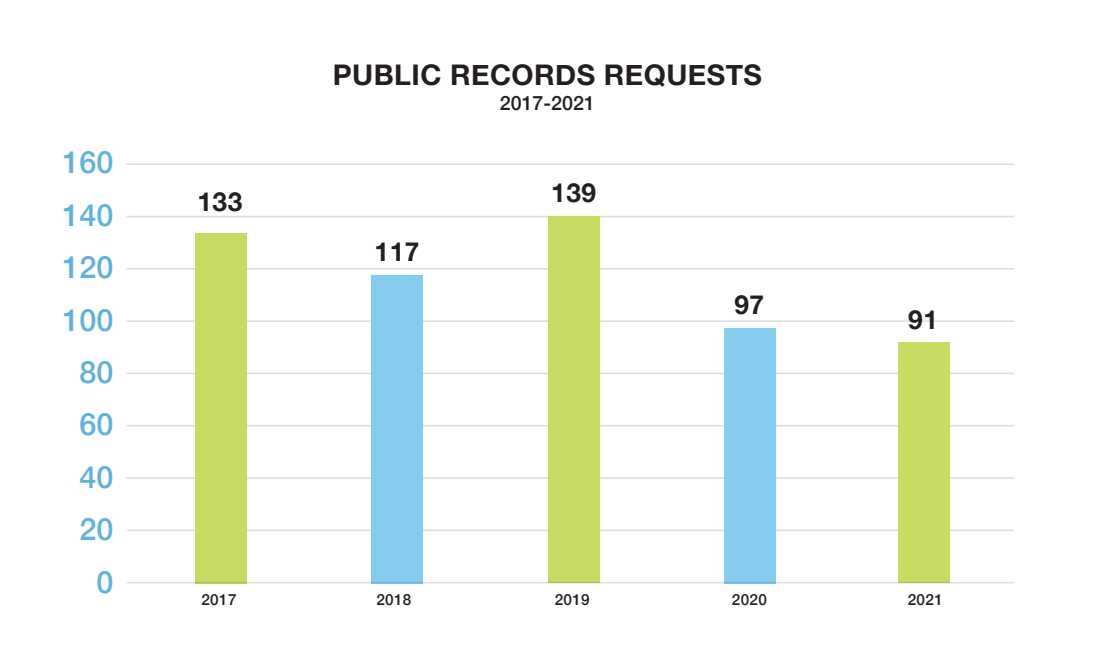


[5]This category has only been tracked since 2020 and therefore, prior years do not exist for comparison.

NON-INVESTMENT TRANSACTIONS
YEARLY COMPARISON 2017-2021

NON-INVESTMENT TRANSACTIONS 2017-2021		
YEAR	TRANSACTION TOTAL	TRANSACTION AMOUNT
2017	68	$5,446,027
2018	63	$2,710,612
2019	87	$1,743,153
2020	133	$4,492,957
2021	151	$10,592,834





In summary, legal support for investment activity has continued to increase year over year. While the volume of work is up, the value of transactions has seen a slight decrease. The increase in volume is attributed mostly to increased activity in Private Equity as well as the Credit/Hedge fund and Real Assets space. In line with the Investment work plan and strategic initiatives for 2021, a focus on operational effectiveness and cost effectiveness resulted in increased co-investment activity and the establishment of a dedicated managed account ("DMA") program. Both of these changes, in turn, resulted in increased legal support to ensure timely onboarding and closing for co-investments and the buildout of the DMA structure, which involved the drafting of numerous legal templates. Legal has also supported the T.I.D.E. initiative through enhanced data tracking and the addition of contractual terms that enable further monitoring and reporting in this area. In addition, legal support for the Real Assets team increased this year as that team continued the implementation of its strategic plan and meeting asset allocation targets. Furthermore, the acquisition of more portfolio and risk management tools, as well as reporting and monitoring tools, has meant additional legal review. In the meantime, there was a decrease in transactions in the separate account Real Estate program as Covid affected the attractiveness of certain property types and the asset class is being restructured and its focus shifted to commingled fund structures. However, this is likely to change in the coming years as the team shifts gears to implement the new strategy. Similarly, legal support for Public Markets saw a drop in activity in 2021 as the Public Markets team reassessed the program's direction. Staff anticipates that future legal needs and support will likely continue to increase given that activity in the Investment space is projected to be strong as the fund has grown in the last few years from $65 billion to $75 billion and will continue to grow, investment structures are getting more complex and sophisticated and compliance requirements are becoming more stringent.

For commercial transactions, both the volume of work and value of contracts increased since last year. In fact, the value of contracts more than doubled year over year. Most of the activity occurred in the Systems Division. This is due to LACERA's focus on modernizing its technology to simplify and improve its operations and a shifting emphasis from onsite capabilities to a remote and hybrid workspace. The contracting for many of the improvements taking place right now actually occurred in 2021, including for tenant migration, cloud storage and the installation of docking stations to support the return to the office effort. In addition to legal support for remote

capabilities improvements, there was also a lot of activity in the area of enterprise risk reduction, such as disaster preparedness, as well as improving member experience, installation of enterprise wifi and bolstering information security. Even as the technology improvement efforts have stabilized, staff expects the transaction volume to remain at elevated levels given that the Systems Division continues to expand the network of subject matter experts and specialty vendors to adjust to a post-Covid world and support an organization with many different constituents and levels of need.

Public Records requests have experienced a slight reduction year over year. Most requests are from investment related data aggregators and reporters. Since staff has moved to publish a lot of frequently requested materials on LACERA's newly revamped website, there has been less activity in this space. In the same spirit, as trends in the type and character of information requested become apparent, staff will make the most frequently requested records readily available online to ensure full transparency and create operational efficiencies. Our continued goal is to provide the highest level of service to the public and LACERA members. Overall staff expects the year over year volume of public records requests to remain relatively the same.

Legal Transactions Year End Report

LACERA

Los Angeles County Employees Retirement Association

LACERA

Documents not attached are exempt from disclosure under the California Public Records Act and other legal authority.

For further information, contact:
LACERA
Attention: Public Records Act Requests
300 N. Lake Ave., Suite 620
Pasadena, CA 91101

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